CURATIVE COMMUNITIES: CREATING HEALING PEOPLE, PLACES AND PROCESSES FOR THOSE SUFFERING WITH MENTAL ILLNESS

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ABSTRACT

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The context of this project was The United Methodist Church of Bound Brook, located in Bound Brook, New Jersey. The problem is that many people, both inside and outside the Church, are suffering from various degrees of mental illness. Unfortunately, the Church is currently not equipped to help them. If the Church could familiarize itself with existing healing tools, then it could be a better partner in the healing process. After participating in this project, the participants will be willing to assist the pastor in starting a mental wellness ministry.

ACKNOWLEDGEMENTS

As I reflect upon the culmination of my Doctor of Ministry journey, I am profoundly grateful for the unwavering support and encouragement extended to me by various individuals such as Dr. Anita Coleman, Dr. James McKeever, and the Rev. Dr. Irving Cotto. I also acknowledge my mentors, the Rev. Dr. Michael Beck and Rev. Dr. Roz Picardo, for their wisdom, guidance, and support in this doctoral experience. I wish to thank my doctoral cohort group members for all their support. Foremost, I express my most profound appreciation to the Bound Brook United Methodist Church members, whose support has been instrumental in realizing this project.

To my cherished church community at Bound Brook UMC, your commitment to pursuing spiritual growth and collective well-being has been inspiring and fortifying. Your unwavering encouragement has provided a foundation for this academic endeavor to flourish. The church community's collective dedication has enriched my academic pursuit. However, it has also affirmed the symbiotic relationship between academia and the vibrant, supportive community I am privileged to serve.

I extend heartfelt gratitude to my beloved wife, Maritza, and my three children, Mcwilliam Jr., Mariellie, and Mercedes, whose unwavering love and understanding have sustained me throughout this academic endeavor. Your patience, encouragement, and sacrifices have been the bedrock upon which I could navigate the rigors of doctoral

studies. Your steadfast support has been my anchor, grounding me in moments of challenge and celebration.

Acknowledging your collective contributions, I remember the proverb, "It takes a village to raise a child." Similarly, it takes a community to support a doctoral candidate. This project has been a collaborative effort, and I am grateful for the collective commitment that has fueled its progression.

In conclusion, I express my deepest gratitude to all those who have played a part, large or small, in this academic journey. Your support has shaped the outcome of this project and enriched my personal and professional growth. Standing on the precipice of a new chapter, I carry the profound lessons and enduring bonds forged during this Doctor of Ministry endeavor.

DEDICATION

This research is dedicated to my beloved wife, Maritza, and our cherished children, McWilliam Jr. and his wife, Alex Marie, along with our daughters, Mariellie and Mercedes, and the joyous addition of my grandchild, McWilliam the 3rd—this doctoral journey bears witness to the strength and unwavering support of our family bond. Your enduring love, encouragement, and sacrifices have been the cornerstone of my pursuit of knowledge and growth. As I celebrate this academic achievement, I dedicate it to each of you, expressing profound gratitude for your steadfast presence and inspiration from our shared journey. This accomplishment is a testament to the enduring power of family and love.

INTRODUCTION

The formulation of my foundational papers not only kindled my intellectual curiosity, prompting further research into the contemporary role of the church in addressing mental health issues within the community, but also reinforced my conviction that the creation of a comprehensive program is imperative for the church to effectively convey the message of Jesus Christ and God's love to all individuals.

In Chapter Two, I provide a synthesis encompassing the Biblical perspective on mental health, the foundational beliefs of the United Methodist Church of Bound Brook derived from the teachings of John Wesley, theological reflections (notably within liberation theology), and contemporary data illustrating the prevalent nature of mental health challenges in our nation. A concise overview of my proposed project on this subject is presented, accompanied by a recent event that solidified my determination to address mental health within our community.

Delving into Biblical scriptures, the narrative of Ruth became a source of profound contemplation. This poignant account unveils a unique perspective when examined through the lens of a well-known narrative. Ruth, an immigrant daughter-in-law, exemplified unwavering loyalty to her mother-in-law, Naomi, during their arduous journey. Naomi, in turn, embodied the struggles of an immigrant facing bereavement and societal displacement. By juxtaposing their experiences, the narrative reveals not only the

challenges of immigration but also the profound impact on mental health, a theme often overlooked.

In Chapter Three, an examination of historical foundations unfolds, transcending centuries to meticulously investigate the profound insights of John Wesley, the eminent founder of the Methodist Church. The critical exploration into Wesley's discourse on "nervous disorders" reveals a remarkable alignment with the contemporary understanding of depression, thereby underscoring the prescient nature of his contributions to mental health discourse. Wesley's elucidation of the intricacies surrounding mental well-being not only attests to his enlightened perspective but also serves as an invaluable source of guidance firmly rooted in the tenets of divine love.

Wesley's approach to mental health emerges as a paradigmatic exemplification of holistic care. His multifaceted understanding encompasses spiritual, psychological, and practical dimensions, exemplifying a comprehensive framework for mental health that transcends temporal boundaries. This discernment, interwoven with theological principles, reflects an enduring commitment to addressing the complexities of mental health within a spiritual and compassionate context.

The interpretation of "nervous disorders" in Wesley's writings denotes a pioneering acknowledgment of the psychological aspects of mental distress, prefiguring contemporary perspectives on depression. His discourse is not merely a historical artifact but an enduring source of inspiration, serving as a theoretical cornerstone for my scholarly pursuit. The incorporation of Wesley's wisdom into the fabric of my research underscores the enduring relevance of his insights, fostering a nuanced understanding of the intersections between faith and mental health. Chapter Four introduces the integration

of liberation theology, which, advocating for justice and compassion, aligns with the church's moral responsibility to address mental health within marginalized communities, particularly evident during the recent COVID-19 pandemic.

In expanding on the integration of liberation theology, it is paramount to comprehend its profound implications for addressing mental health within the context of marginalized communities. Originating from the visionary insights of a Catholic priest in Latin America, this theology stands as a compelling call for Christians to champion the liberation of individuals oppressed by poverty, racism, and social injustices—pervasive realities rather than exceptions in these regions. Liberation theology encourages believers to engage with the world through lenses of love and compassion, underscoring the Christian Church's mandate to advocate for justice in the name of God, eschewing political or economic motives.

The nexus between liberation theology and mental health becomes apparent when considering the socioeconomic disparities that afflict the underprivileged segments of a community. These marginalized individuals often grapple with mental health issues compounded by a lack of resources, a circumstance that propels them toward seeking solace and assistance within the walls of a church, their last bastion of hope.

Liberation theology applied to mental illness underscores the spiritual significance of recognizing the economic dimensions of mental health oppression and its inherent linkages to poverty. Individuals grappling with mental health challenges are often denied adequate social support and, regrettably, deemed to possess little social consequence. This paradigm is increasingly criticized in contemporary literature, which perceives current mental health treatment approaches as dehumanizing and oppressive.

In navigating these complex intersections, the church is not merely bestowed with a medical responsibility; it carries a moral obligation. Embracing Christian morality, as Jesus advocates, entails a proactive commitment to loving neighbors and extending holistic assistance to individuals as complete entities. The call to practice charity, solidarity, and accompaniment resonates profoundly in the church's work with individuals situated at the margins and beyond. Integrating liberation theology into the church's response to mental health challenges accentuates the moral imperative to address the systemic issues perpetuating suffering, advocating for justice and compassion as integral components of a holistic healing approach.

In Chapter Five, Murray Bowen's family systems theory becomes a focal point, exploring the concept of a "generational curse" and its profound implications on mental health. The theory's application within the church setting is highlighted, emphasizing the importance of holistically understanding family dynamics in addressing mental health issues.

This academic exploration aims to illuminate the intricate intersections of biblical principles, historical perspectives, theological insights, and psychological theories, culminating in a comprehensive understanding of mental health within the church context.

CHAPTER ONE

MINISTRY FOCUS

Established in 1847, The United Methodist Church of Bound Brook is a testament to the community's enduring commitment to its rich history and Christian values. Dedicated to the principle of welcoming all people, this church profoundly emphasizes developing meaningful relationships with one another and with Jesus Christ. As a diverse community of faith, the congregation extends its concern beyond its walls to actively seek ways to make a positive impact in the lives of others in the name of Jesus Christ.

The United Methodist Church of Bound Brook, in the oldest established town in Somerset County, New Jersey,[1] holds a distinctive position in the community's narrative. The municipality of Bound Brook itself has roots dating back to 1681[2] when a settlement was founded close to the Bound Brook stream, a watercourse that derives its name from a Native American deed. This stream flows from the Green Brook on the borough's eastern edge into the Raritan River, encapsulating the geographical and historical significance of the region.

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[1] Arnold, Joseph L. The new deal in the suburbs: a history of the greenbelt town program, 1935-1954. The Ohio State University Press, 1971.

[2] *History of Hunterdon and Somerset Counties, New Jersey: With Illustrations and Biographical Sketches of Its Prominent Men and Pioneers*. Everts & Peck, 1881.

The Queen's Bridge, an architectural gem constructed in 1761,[3] serves as a symbolic representation of community strength and resilience. Initially a timber span across the Raritan River, the bridge transformed over the years into a covered bridge and later a steel pipe truss bridge in 1875. Despite facing the challenges of the American Revolutionary War, notably at the Battle of Bound Brook in 1777,[4] the bridge has endured as a tangible link to the community's storied past.

This historical context is not merely an anecdotal backdrop but is integral to The United Methodist Church of Bound Brook's identity. In Alex Haley's *Roots,* we are reminded, "In every conceivable manner, the family is linked to our past, bridge to our future."[5] Mahatma Gandhi said, "A nation's culture resides in the hearts and in the soul of its people."[6] The great civil rights leader, Rev. Dr. Martin Luther King Jr., stated, "Faith is taking the first step even when you don't see the whole staircase."[7]

These quotes highlight the interconnectedness of the congregation, the rich historical legacy of Bound Brook, and the abiding faith that serves as the foundation for The United Methodist Church of Bound Brook's ministry. In embracing its existence's temporal and spiritual dimensions, the church remains poised to continue its legacy of community service and spiritual nurture for generations to come.

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[3] Richman, Steven M. *The Bridges of New Jersey: Portraits of Garden State Crossings*. Rutgers University Press, 2005.

[4] Wood, William J. *Battles of the Revolutionary War, 1775-1781*. Vol. 3. Algonquin Books, 1990.

[5] *Haley, Alex. Roots. Boston, MA: G.K. Hall, 1977.*

[6] Caswell, Cathy. "Culture. In Our Hearts and Soul." The Healthy Living Plan. February 1, 2023. https://thehealthylivingplan.com/culture_ghandi_logosynthesis/.

[7] Edelman, Marian Wright. "Children's Defense Fund." *Cleveland Plain Dealer*. 1967.

The Battle of Bound Brook, which took place on April 13, 1777, was a part of the New York and New Jersey campaign of the American Revolutionary War. After being dispersed by about 4,000 British-led forces, the Continental Army was defeated in this battle.[8]

The town of Bound Brook has changed considerably, but there have also been numerous constants. The town of Bound Brook is a tiny community that values its relationships with one another. From the seasoned businessperson to the lifetime resident and everyone in between, This small town of Bound Brook offers community, something many New Jersey towns need to improve. The community of Bound Brook is once more ready to achieve great things.[9]

In the same way, the congregation of Bound Brook United Methodist Church is ready to achieve great things. While the congregation comprises a full spectrum of ages and family situations, most church members are from 50 to 70 years of age.[10] Within this age group, 33% are not active in the life of the church community.[11] About 40% of those in the 30-49 age range are not involved in the life of the church community.[12] The young adult age group presents a challenge for our congregation, with about 66% of young adult

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[8] Wood, William J. *Battles of the Revolutionary War, 1775-1781*. Vol. 3. Algonquin Books, 1990.

[9] "History." Bound Brook, NJ. Accessed March 27, 2023. https://boundbrook-nj.org/history/.

[10] "Church Profile." n.d. Www.umdata.org. Accessed February 5, 2023. http://www.umdata.org/ChurchProfile.aspx?ChurchID=023227.

[11] "Church Profile." n.d. Www.umdata.org. Accessed February 5, 2023. http://www.umdata.org/ChurchProfile.aspx?ChurchID=023227.

[12] "Church Profile." n.d. Www.umdata.org. Accessed February 5, 2023. http://www.umdata.org/ChurchProfile.aspx?ChurchID=023227.

members not being active in the life of the church.[13] Our church children and youth population attend church with some of the few young parents that attend church.

While the congregation comprises a full spectrum of ages and family situations, most church members are from 50 to 70 years of age. Within this age group, 33% are not active in the life of the church community. About 40% of those in the 30-49 age range are inactive. The young adult group presents a challenge for our congregation, with about 66% of young adult members being inactive. Our children and youth population is close to nonexistent.

In 2017, Bound Brook, New Jersey, had 10,500 people with a median age of 35.1 and a median household income of $65,199. The population of Bound Brook has been stable for the last ten years. The five largest ethnic groups in the community are White (Hispanic) (43.5%), White (Non-Hispanic) (41.2%), Some Other Race (Hispanic) (6.66%), Black or African American (Non-Hispanic) (4.03%), and Asian (Non-Hispanic) (1.98%). 55% of Bound Brook, New Jersey, speak a non-English language, and 81.9% are U.S. citizens. The median property value in Bound Brook, New Jersey, is $270,900, and the homeownership rate is 50.8%. Fifty-one percent consider themselves "spiritual," yet only 22% find it necessary to attend religious services.[14]

The town of Bound Brook is a close-knit community. People try to celebrate and work as a community for the greater good of all. They do this by having the fire

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[13] "Church Profile." n.d. Www.umdata.org. Accessed February 5, 2023. http://www.umdata.org/ChurchProfile.aspx?ChurchID=023227.

[14] "U.S. Census Bureau QuickFacts: Bound Brook Borough, New Jersey." n.d. www.census.gov. https://www.census.gov/quickfacts/boundbrookboroughnewjersey.

department run by volunteers and having a chaplaincy program within the police department.

Bound Brook started to transition to a community with a majority of people of color about 15 years ago when the big pharmaceutical companies left the region and the country. The buildings and land those companies vacated were transitioned to warehouses. Before the pharmaceutical companies' departure, the Bound Brook community was majority White (non-Hispanic) with post-undergraduate education. The congregation of the United Methodist Church of Bound Brook reflected this reality.

The buildings of the United Methodist Church were built by many hands over many years. The founding membership left a strong legacy for subsequent generations. While there has been effective pastoral leadership, then and now, the lay leadership made the decisions to build their church buildings in three different phases. Phase one occurred in 1847, when the Bound Brook Methodist Episcopal church was established. At that time, the founding members of the church decided to build a two-story building that housed the sanctuary on the second floor and Sunday school rooms on the first floor. Over the next 70 years, the congregation built two other buildings and a parsonage on the same plot of land they purchased in 1847.

The leadership of the United Methodist Church of Bound Brook was always looking forward. Considering this history, it becomes apparent that the early leadership of this church left a legacy to support their faith community and beyond the walls of the Church out into the larger community. As a faith community, this congregation has continued to strive both to minister to the church family and to go beyond the walls to serve the community in which it is situated.

The vision for The United Methodist Church of Bound Brook is “to be a thriving, Spirit-filled church committed to changing lives through sharing Christ's love.” The Mission Statement of The United Methodist Church of Bound Brook says that “we share Christ's love by our lives (Discipleship), actions (Mission), and words (Witness).” The congregation of Bound Brook believes that their mission and vision statements are in harmony with the denomination's mission, which is “to make disciples of Jesus Christ for the transformation of the world.”[15]

The current leadership of the United Methodist Church of Bound Brook says: "Our Church is a fellowship of healing, living, learning, rediscovery, and sharing the Gospel of salvation. We are an accepting church community reaching out to everyone, fashioned after Christ's love and God's grace." I am encouraged by the last part of this statement. In the United Methodist Church's current climate of contention around the issue of homosexuality, a mission statement that emphasizes the acceptance of a church community speaks volumes.

The United Methodist Church of Bound Brook is well-positioned to meet the challenges laid before them. This congregation has strong leadership dedicated to doing amazing ministry in the Bound Brook community and beyond. The United Methodist Church of Bound Brook has established missions that reach beyond the doors of the church, and the church is dreaming big dreams. For the first time in a long while, the congregation's financial situation is stable, and the congregation are meeting their financial obligations.

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[15] Thomas, Sara B. "A missional approach to discipleship in the United Methodist Church." (2015).

The United Methodist Church of Greater New Jersey is currently facing great challenges. These were brought to light in the Greater New Jersey Conference by studying historical trends and future projections. The Greater New Jersey Conference found that over the last ten years, worship attendance has declined by 20%, professions of faith by 34%, and annual baptisms have fallen from 3,321 to 1,882.[16] During the Conference's episcopal address, Bishop John Schol presented a study of historical trends and projections for 2030. This study indicates that without major systemic changes, by 2030, the annual conference of the Greater New Jersey will have a decline of 12,981 worshipers, which could lead to the closing of over 123 of our current 455 congregations.

Hearing this Episcopal Address empowered me to address the status quo of the congregation of The United Methodist Church of Bound Brook and initiate plans to reverse those trends. The United Methodist Church of Bound Brook can no longer dwell on what once was. Instead, the focus needs to be on what the congregation can do today to make a difference for tomorrow and for generations to come.

As the United Methodist Church is trying to survive during this time of post COVID-19, the congregation of Bound Brook is facing a higher level of major depressive episodes and anxiety disorders, particularly among the children and youth of our congregation. Some of our church children and youth have tried to harm themselves by cutting or have even attempted suicide. In my experience in going to church all my life I understand that, unfortunately, faith communities have historically stigmatized treatment for mental health within the faith communities. In some cases, people speak of mental illness as the "work of the devil." The church and its pastoral leaders need to understand

[16] Bishop John Schol, "Episcopal Address" (Greater New Jersey Annual Conference Wildwood New Jersey, 2019).

when our congregation members require support from a mental health professional, and when they need spiritual support from the Church.

In September of 2021, I found myself looking for mental health support for one of my children. In my search I learned that finding help for mental illness is complex. My wife and I have post-undergraduate degrees, yet we found the mental health system challenging to navigate at best. The process of looking for help for my child and some of the children and youth from my church has taught me several things. What I learned was that I need to be present, I need to listen and not always provide solutions. I need to be intentional and make sure that I engage them, even if the child is pulling away. The questions I ask them should be about finding information. I should ask what they need from me. What can I do to be useful or helpful to them? Of course, praying for and with them when they ask for prayer is important. Prayer should always be available.

In some faith traditions, mental illness has been so stigmatized that it has been called a generational curse. In my research for my daughter, I saw many religious organizations that would accuse someone with mental illness of having a demonic spirit. The church people would tell young people dealing with mental illness that this demonic spirit would leave them if they would pray.

The story of my daughter is not unique. She is a young lady who grew up in the church. Moreover, when she found herself struggling with mental illness, she turned to prayer; she turned to God. I believe in the power of prayer, the power of the Holy Spirit, and Jesus Christ's healing power over us, and that is what was instilled in my daughter. She was confident that she could overcome her illness with prayer. She turned to her parents for help. Initially, my wife and I, not understanding all that is entailed with

mental illness, also turned to prayer, not recognizing or understanding what mental illness has done and continues to do with our children, youth, and our community and beyond.

We turned to the only thing we knew, prayer—not seeing and recognizing that my daughter was stigmatized by the church that nurtured her in the Word of God. The church membership made her feel that she had something unholy in her, but the church did not understand and could not recognize the many signs of mental illness. Furthermore, the church could not see what mental illness was doing to our church and community children and youth. Rather than helping, the church was hurting my daughter and children and youth that were facing similar health issues.

As mental health issues have become more visible during COVID-19, so too has domestic violence. According to the National Coalition Against Domestic Violence, women make up 85% of the victims of domestic violence. An estimated 1.3 million American women experience domestic violence each year.[17] Despite this, most cases are never reported to the police. Most women are victimized by people they know. In the Bound Brook community, we have found an increase in domestic violence calls to the police department. According to Bound Brook Chief of police, Chief Beto, the Bound Brook community has the most domestic violence calls in the state.[18]

The community of Bound Brook is about 60% persons of color, more than half of whom are women. According to the National Coalition Against Domestic Violence, these women are statistically more vulnerable. Women of color are almost three times as likely

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[17] "National Statistics Domestic Violence Fact Sheet." The National Coalition Against Domestic Violence. National Coalition Against Domestic Violence, January 15, 2023. https://thehealthylivingplan.com/culture_ghandi_logosynthesis/.

[18] Police Chief Beto, "Community Meeting Presentation," (Bound Brook New Jersey, November 2020).

to experience death due to domestic violence than white women. Furthermore, while women of color only make up 8% of the population, 22% of homicides that result from domestic violence happen to women of color, and 29% of all victimized women, making it one of the leading causes of death for women of color aged Fifteen to Thirty-five. Women of color experience sexual assault and domestic violence at disproportionate rates.

I mention domestic violence in the Bound Brook Community because domestic violence in households can affect our children and youth's emotional and mental state. Domestic abuse has long-lasting repercussions on the victim and any family members, friends, or other close relatives who may be exposed to or aware of the abuse. Abuse may hurt our self-esteem, self-care practices, and interpersonal interactions. Beyond that, domestic abuse can significantly negatively impact our feelings and occasionally result in severe and persistent mental health issues. There is a strong connection—even a cyclical one—between domestic abuse and mental health. You see, those with mental health issues are much more likely than those who do not become victims of domestic abuse.

Domestic violence is an incredibly terrible and emotional reality in many families across New Jersey and the rest of the country. Victims understandably frequently feel intense emotions even after being freed from an abusive home or relationship. Victims need emotional support to process and recover from their trauma healthily. The mental health effects of domestic violence are likely to be severe and long-lasting. Exposure to violence and abuse increases one's risk of experiencing post-traumatic stress disorder, depression, anxiety, substance use, and suicidal behaviors. These are the behaviors our

children and youth of our Church are facing. The Church must and needs to be a healing agent.

A multifaceted strategy is needed to address domestic abuse, including trauma-informed and culturally sensitive legal and policing services, specialized mental health treatments, and widespread community activities involving religious organizations. Mental health services need to be ready for increased demand and caseload as we enter new stages of the pandemic.

Each of us, through our baptism, is called a minister. With God's help, our ministry can be compelling and transformative. Through our words and actions, we can positively influence family, friends, colleagues, neighbors, and those we meet in ways that will lead to a better world. As people of God, we need to create new ministries, nurture our children in the Church's life, practice extravagant generosity, and invite others to join in worship, mission, and fellowship. In word and deed, we share our faith with others when we do these things. Our congregational life together can be broken down into several key areas. These include Christian hospitality, nurture, worship, discipleship, and outreach.

Of the many statistics reviewed here, the ones that concern me most are the lack of participation from children, youth, and young adults. Among the handful who are participating, many are hurting themselves. When the church does not have active children, youth, and young adults in its ministry, it dies slowly and painfully.

As stated previously, this community has a strong, economically stable, and diverse Latino presence. People from all over Central America and South America live in the Bound Brook surrounding community. Because of this, the congregation of The

United Methodist Church of Bound Brook dreamed big and established two worship services. One in English and the other in Spanish. The Spanish service has children, youth, and young adults who participate in the life of the church. I'm concerned that the English service does not have many children, youth, and young adults participating in the Church's life.

There are seven functions or elements pastoral leadership needs to fulfil their role in the community and beyond. These seven functions are advocacy, care, healing, proclaiming, administering the sacraments, reconciling, and being part of human development.

The modern western Church has been in decline for decades. In this most recent decade, most pastors have been doing ministry in a declining church. When looking at the current landscape of the Church, we see churches that have dropped in those attending and worshiping on Sunday mornings. There are exceptions, but even those whose membership has declined are trying to do great ministry beyond their communities.

I believe I have most, or all of the functions identified in my tool kit. When churches struggle with growth, they have generally not adopted these key elements. They have been missing out on what is vital in their communities. Churches have concentrated on keeping tradition and scripture, believing that in doing so, they will fill people spiritually. Pastoral leadership misses the mark when it only concentrates on the soul. My upbringing gives me a different perspective on doing pastoral leadership at the margins.

Pastors need to advocate for the community where God has planted them. They must protect the parishioners and fight for justice in the community and beyond. I have too often seen churches in marginalized communities where the parishioners attending

the churches do not live in that community. Because of the membership makeup, pastors become preoccupied with caring for their own group instead of protecting a marginalized community. Throughout my adult life, I have worked for the public sector and advocated for the least of these. Working for the Philadelphia Mayor and serving as a political consultant, I have gained many contacts that will help in my Doctor of Ministry Project.

The second function of pastoral leadership is to care for the people served. Many times, pastors are concerned about the building or its property, sometimes to the neglect of the community. I recently found myself in this situation. On September 1st, 2021, Hurricane Ida hit the state of New Jersey. My church is in Somerset County, one of the areas hardest hit by the storm. The church I serve received damages totaling over $250,000 to repair damage done to the church. Over the past few months, the building and the church's properties have consumed my focus. I am just now coming full circle in leading our congregation to the marginalized. It is not about us; it is about Jesus, who in the scriptures reminds us to care for the marginalized. We are to care for the broken, going beyond our walls to have a more significant impact on the Church's ministry.

An essential Biblical principle for understanding the Church and the function of laypeople in the Church is the idea of caring for all people. It means that everyone who identifies as a Christian has been called and given the power to serve as a minister to others and a channel for God's grace in their lives. It implies that the belief that laypeople serve as consumers while clergy engage in ministry is false and antithetical to Scripture.

We are blessed with the power of love, which enables us to serve as ministers to one another. Through His ultimate sacrifice, Christ demonstrated the true essence of God's grace. It is now our responsibility to carry on this mission. To be a part of the

Church means that we have personally experienced God's love, acceptance, and forgiveness, and we have devoted our lives to extending Christ's ministry of grace to others.

All believers share in this ministry in partnership with Jesus Christ. According to 1 Peter 2:4-5, 9-10:

> As you come to him, the living Stone—rejected by humans but chosen by God and precious to him— you also, like living stones, are being built into a spiritual house to be a holy priesthood, offering spiritual sacrifices acceptable to God through Jesus Christ. But you are a chosen people, a royal priesthood, a holy nation, God's special possession, that you may declare the praises of him who called you out of darkness into his wonderful light. Once you were not a people, but now you are the people of God; once you had not received mercy, but now you have received mercy.

The Church's mission is to make Christ present for others and to show Christ in all aspects of life—family, job, play, etc.— to make Christ real. The Church is a ministry of love, not a structure or organization. The Body of Christ in the world, the congregation of ministering Christians, and the royal priesthood collectively comprise the Church. We are the Church wherever we are; we do not merely belong to it.

God has placed the keys to the reign of God in our hands, giving us the authority to bind or unbind individuals depending on how we distribute or withhold the grace He has bestowed upon us. God can speak to someone suffering by saying, "God loves you," "You are forgiven," or simply by answering a simple prayer. The presence of God can be felt by someone drowning in hardship or despair in the form of a hand on the shoulder, the company of a friend, or an offer of assistance.

With the character of our entire life, "declare the great deeds of God." This may entail bringing hope during difficulties, reflecting light during darkness, or combating the fatal attitudes of selfishness, cynicism, fatalism, and hopelessness pervasive today. We

now have the chance to embrace the Gospels in our daily lives. To make Christ accurate in our circumstances so that others may understand God's salvation is that everyone has a personal, non-transferable mission. Let us address our world's current spiritual leadership problem by being the Church wherever we stan.

Because I was reared in the margin of a poor working-class community in Philadelphia, my pastoral leadership has attempted to ensure the Church is a safe place where people can find healing. A recent poll done by Pew indicates that churches are not places where people feel welcomed or find healing.[19] Yet healing must be a key component of what pastors accomplish daily. Healing whatever affects the relationship and helping people leave whatever baggage keeps them away from God should be a significant focus of a pastor's work. The sanctuary of the Church needs to be where people can find the grace of God, the love of God, and the promise of hope.

As pastors are advocates, caring for the community, and making the Church a safe place, they cannot forget to proclaim the good news of Jesus Christ to their community. Pastors need to make sure the Church welcomes all people, regardless of race, status, and whomever they choose to love. Proclaiming the Gospel and proclaiming healing to a broken community is what pastors are called to do.

As the senior pastor of the United Methodist Church of Bound Brook, my responsibilities include administering the sacraments. I have seen churches that do not regard the sacraments as critical. But having communion regularly feeds the community of believers looking to find a higher being. Providing the means of grace through the sacraments will help to ensure a healthier congregation. Some churches emphasize the

[19] "Decline of Christianity," 2019, https://www.pewresearch.org/religion/2019/10/17/in-u-s-decline-of-christianity-continues-at-rapid-pace/

Lord's table more than the baptismal font. In others, the baptismal font is vital to the church's ministry. The baptism font is located right in the middle of the altar.

Unfortunately, most churches have placed the baptism font in a corner out of the way. They only place the font in the center when the Church has a baptism. Churches may have the offering plate, candles, and other elements on the Lord's table, but they do not have the symbolism of the bread and juice there.

When people come to the table or the baptism font, the Church allows them to find reconciliation with God. When people are reconciled with God, their faith grows stronger. To grow in their faith, they need to know more about God. The Church needs to start developing Bible study and small group ministries. The Church is a place where people should grow in their faith, find encouragement, and explore all aspects of spiritual education.

Jesus provided us with sacraments through the scriptures' explicit guidance and examples. By way of external, tangible indications, sacraments engage our physical senses. They also engage our spiritual senses through an internal, spiritual act of grace. According to the specific tradition or denomination doctrine, the church celebrates a different number of sacraments. Two sacraments are recognized by the majority of Christians, including my faith tradition: baptism and the Lord's Supper or Holy Communion. Regarding the numerous customs of other faiths, Christians must have a loving and humble attitude. John Wesley once observed, "We may not all have the same beliefs, but we can have the same love."

When the pastor incorporates the seven functions, the Church can, as the book Canoeing the Mountain states. "We can create an organizational culture and more people

toward a transformation." That is precisely what the lay leadership and clergy alike are called to do.

I have encountered these seven elements or functions in my spiritual journey. They have transformed me and helped me answer my call to ministry. Let me share a little bit of my faith journey.

I grew up in a Latino church in Philadelphia, where advocacy was the center of their vision and mission. I saw my pastor regularly fighting for social issues affecting the members of my church. The church I grew up in was in a poor community in the inner city. As a child, I did not realize that I and this community were poor. But I understand that poverty as I look back. My pastor was always trying to hold our elected officials accountable. This community also needed to be more represented. My passion for going into public service and working for local politicians comes from the model of advocacy my pastor gave me.

In my ministry, connecting advocacy to God's call for each one is crucial to me. One of the strengths that I bring to the table is how I join the church to the community. I remind my congregation that we are to be the hands and feet of Christ in a marginalized community. Churches need to look like the community they are planted in and grow there.

I want to highlight the other key element I have experienced myself: support. My wife was raised in a family where education was not an essential goal. Achieving a high school diploma and going to work was good enough for them. To this day, my wife thanks God for her pastor, who reminded her regularly that she was capable of much more. Through the United Methodist Church, she received scholarships and grants that

helped her attend college for free. Through the United Methodist Church and her local community, she found tutors who helped her through the difficult times of undergraduate work. United Methodist Church missionaries also encouraged her and helped her develop her skills and knowledge to become a local pastor. She is an example of the way the Church can change a marginalized community through education.

The other example involves me. I had the opportunity to work for the mayor of Philadelphia, Wilson Goode. This opportunity came about because the Church groomed me to be an effective leader who understands how to help people.

In *Canoeing the Mountains*, Tod Bolsinger writes that leadership itself is a practice.[20] The Church allowed me to practice and develop my skills. I was encouraged to act. I hope I am the type of pastor who allows the church leadership to practice and develop their skills just as I did. I want to use my pastoral role to encourage my congregation to act with mercy and compassion.

As I previously mentioned, during this time of COVID-19, the United Methodist Church of Bound Brook has faced a higher level of major depressive episodes and anxiety disorders. Domestic violence has become more visible in the community of Bound Brook. According to the National Coalition Against Domestic Violence, women who suffer from domestic violence are victimized by people they know.

I am concerned that we have children and youth hurting themselves. How can The United Methodist Church of Bound Brook be a place of healing, where children and youth can feel comfortable asking for help? I would love it if this Church of Bound

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[20] Bolsinger, Tod E. *Canoeing the mountains: Christian leadership in uncharted territory*. Downers Grove, IL: IVP Books, an imprint of InterVarsity Press, 2018.

Brook could establish a counseling center where people from the community and beyond can seek help to heal the body, mind, and soul.

I hope that the members of our church will act in a way that is characteristic of a life based on Christ and that results from a connection with and dedication to Christ. Christian activity entails working in ways that honor Christ and his church. According to Luke 10:29-37:

> But he wanted to justify himself, so he asked Jesus, "And who is my neighbor?" In reply, Jesus said: "A man was going down from Jerusalem to Jericho when robbers attacked him. They stripped him of his clothes, beat him, and went away, leaving him half dead. A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. So too, a Levite, when he came to the place and saw him, passed by on the other side. Nevertheless, a Samaritan, as he traveled, came where the man was; and when he saw him, he took pity on him. He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, brought him to an inn and took care of him. The next day he took out two denarii and gave them to the innkeeper. 'Look after him,' he said, 'and when I return, I will reimburse you for any extra expense you may have.' "Which of these three do you think was a neighbor to the man who fell into the hands of robbers?" The expert in the law replied, "The one who had mercy on him." Jesus told him, "Go and do likewise.
> The Church bears witness to Christ wherever the church may be, in all church say and does.

Acts 1:8 says, "But you will receive power when the Holy Spirit comes on you; and you will be my witnesses in Jerusalem, and in all Judea and Samaria, and to the ends of the earth."

The Church carries on Christ's work of reconciliation in the world according to your gifts. 2 Corinthians 5:18-20 says:

> All this is from God, who reconciled us to himself through Christ and gave us the ministry of reconciliation: that God was reconciling the world to himself in Christ, not counting people's sins against them. And he has committed to us the message of reconciliation. We are therefore Christ's ambassadors, as though God were making his appeal through us. We implore you on Christ's behalf: Be reconciled to God.

A natural response to God's grace is to live a Christian life. God's grace empowers, frees, and enlightens us. Grace makes us aware of the most important truths in our lives: God's atoning love and the fact that we are all spiritual descendants of God, having been created in God's likeness. We naturally want to spread God's grace with others when we receive the greatest. God's grace inspires zeal for extending it to others. According to the abilities God has given each person, people respond differently to grace through Christian activity.

We have been given the Holy Spirit. Those who have received the gift of the Holy Spirit display spiritual qualities that, in Galatians 5, Paul calls the fruit of the Spirit: love, joy, peace, patience, kindness, generosity, faithfulness, gentleness, and self-control. The fruit of the Spirit results from God's grace coming alive in us; each is an avenue of Christian action.

In 1st Corinthians 13, Paul makes us aware that we receive spiritual gifts for ministry. He clarifies that the most excellent gift is love; without love, all other gifts are empty.

God gives these abilities to the entire church body, not just a few outstanding people who wish to use them privately. Christian action necessitates a strategy. Christian action does not occur by chance; instead, it is decided to express Christ's love in particular ways in word and deed.

Believe that the Holy Spirit will give Believers power and support when they act on their beliefs. Christians who follow Jesus do not put their families, jobs, churches, or communities last to serve the Lord. Christian action is a way of life that takes place daily rather than sporadic acts of bravery. While you engage in Christian action, the rest of

your life cannot remain motionless. Christian activity can only be postponed once you have fulfilled your basic needs. Every action taken in the Christian life is a Christian action. We must always remember that the Holy Spirit will lead and inspire Christian behavior.

Remember that living a Christian life is a thankful response to God's grace, propelled by the Holy Spirit, which enables us to become more like Christ. Engaging in Christian activity inspires the pious to live up to the divine image in which they were made; they live up to their potential of loving God and their neighbor as themselves. Christ's work is furthered by Christian action. God depends on us to carry on Christ's mission in the world.

My prayer is that my Doctoral of Ministry project would provide people the opportunity to seek and find counseling help for marriage, anxiety, and depression. Establishing a counseling center at the United Methodist Church would make this congregation a place of healing. Youth and young adults would know they are welcome in God's house just as they are. Everyone is welcome.

My personal experience has also equipped me, as dealing with the lack of resources has motivated me to provide the best counseling program available. My love for the local church and my concern for its growth is another factor in the success of this project. Everything healthy grows, and the local Church should be the same way. It should grow spiritually and numerically, relationally, financially, and visibly in the community should be high.

Through this Doctoral of Ministry project, I hope to learn how to gather counseling resources from other churches and organizations that have ventured into counseling programs.

CHAPTER TWO

BIBLICAL FOUNDATIONS

The book of Ruth is a fantastic story that invites readers to reflect on how God is involved in the day-to-day joys and hardships of their lives. There are three main characters in the book of Ruth: Naomi, her daughter-in-law Ruth the Moabite, and Boaz, the Israelite farmer. Their story is told in four beautifully designed chapters, which will now be explored.

Named after the prominent person of a Moabite woman who married the son of a Judaean couple living in Moab, the Book of Ruth dates from the period when the judges ruled over Israel. [1]

Naomi and her family were from Bethlehem. They had initially immigrated to the neighboring country of Moab because of a great famine. While the family was living in Moab, her husband died, and her two sons married women from Moab, one named Ruth and the other named Orpah. And then, within ten years, both of Naomi's sons died.[2]

Naomi and her daughters-in-law hear there is food in Bethlehem, Naomi's hometown. She hears that the Lord has visited the people and provided them with food.

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[1] J Vernon Mcgee, *Ruth* (Nashville, TN: Thomas Nelson, 1991), page 19.

[2] Dahl, The Rev Cory. n.d. "The Story of Ruth Teaches Us to Not Jump to Conclusions." Green Bay Press-Gazette. https://www.greenbaypressgazette.com/story/news/local/door-co/opinion/2018/05/04/faith-bible-story-ruth-teaches/578993002/.

Naomi decides to return to her native land. Though Naomi told her to stay in Moab, Ruth chose to accompany her.[3] Ruth did not listen to her mother-in-law, as noted in CHAPTER-VERSE REFERENCE: Nevertheless, In Ruth 1:16-17 Ruth replied, "Do not urge me to leave or return from you. Where you go, I will go, and where you stay, I will stay. Your people will be my people, and your God my God. Where you die, I will die, and I will be buried there. May the Lord deal with me, be it ever so severely, if even death separates you and me."[4]

As Naomi's story unfolds, it reveals a strong relationship between the two women. However, this strong relationship is not enough to lift Naomi's spirits. When these two women arrive at Naomi's hometown, the women and the community recognize Naomi and greet her by name. This demonstrates the status Naomi had before leaving her hometown. However, she rebuffs their greeting, saying, "'Do not call me Naomi,' she told them. 'Call me Mara because the Almighty has made my life very bitter. I went away full, but the Lord has brought me back empty. Why call me Naomi? The Lord has afflicted me; the Almighty has brought misfortune upon me.'" Ruth 1:20-21

Naomi's rebuke contains a play on words. She tells the woman, do not call me Naomi (happy); call me Mara (bitter). Naomi, essentially told the community, "I am a bitter old woman now, and it is God's fault." In reading Ruth, readers learn that Naomi had an immigrant story. She travels to a new land for a better life, her family initially finds what they are looking for there. They started forming new families; Naomi and her family seemed happy until tragedy struck her three times. The grief of losing her family

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[3] Katharine Doob Sakenfeld, *Ruth* (Louisville, KY: John Knox Press, 1999), 55

[4] All scriptures are in New International Version unless it is indicated.

and the shame of returning empty-handed to her home country. Naomi finds herself naming her bitterness.[5]

Chapter one opens with this line, "In the days when the judges ruled," recalling the very dark and challenging days in the book of Judges. Here we meet an Israelite family in Bethlehem struggling to survive famine. In search of food, they move on to the land of Moab—Israel's ancient enemy. The family's father dies, and the sons marry two Moabite women, Ruth and Orpah. Then the sons die, too, leaving only Naomi and these new daughters-in-law. Naomi has no reason to stay anymore, so she tells her new daughter-in-law that she is returning home. Naomi knows that the life of an unmarried foreign widow in Israel will be tough.[6]

So, she compels the women to stay behind. Orpah agrees, but Ruth does not. Ruth shows remarkable loyalty to Naomi, saying, "Wherever you go, I am going to go, your people will become my people, and your God will become my God." Ruth 1:16

The "re-naming" of Naomi to Mara recalls a scene from the Israelite Exodus many years prior. In Exodus 15, following the miraculous crossing of the Red Sea and the subsequent "Song of Moses," it is recorded that the Israelites went into the "wilderness of Shur." After wandering for three days and finding no water, the people visit Marah.[7] This place is identified as a spring of bitter and undrinkable water. The Israelite people "grumble" to Moses, who, in turn, seeks the counsel of the Lord. God

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[5] Giles, Terry, and William J. Doan. *The Story of Naomi--The Book of Ruth: From Gender to Politics*. Vol. 13. Wipf and Stock Publishers, 2016.

[6] De-Whyte, Janice Pearl Ewurama. "Tamar and Naomi-Ruth: Widows." In *Wom (b) an: A Cultural-Narrative Reading of the Hebrew Bible Barrenness Narratives*, pp. 242-269. Brill, 2018.

[7] Robinson, Bernard P. "Symbolism in Exod. 15: 22-27 (Marah and Elim)." *Revue Biblique (1946-)* (1987): 376-388.

directs Moses to take up a piece of wood and throw it into this undrinkable water. The result is that the bitter water becomes sweet. [8]

This Exodus experience in the wilderness parallels the Naomi narrative in many ways. The Israelite community is wandering in an actual wilderness, while Naomi wanders through an emotional wilderness that could be defined as depression. The Israelites come upon a location with water, which should be a source of life, yet the water is bitter, transforming what should be a place of life into death. In her life journey, Naomi was once "full" of life, having a husband and two grown sons. Naomi and her family had accomplished the immigrant dream. However, Naomi returns bitter and empty, transforming what should be a time of life and joy for her into a time of bitterness. The water of Marah in the Exodus story only became sweet when God provided the means to transform bitterness into something life-giving.

In the next chapter, Naomi and Ruth speak about where they will find food. This is the beginning of the barley harvest.[9] Ruth, the young Moabitess woman, finds Boaz's field. Boaz is Naomi's relative, and the text says he is a man of noble character. Naomi encourages Ruth to go into Boaz's fields during the harvest and glean, and Ruth finds favor in Boaz's eyes.

Boaz sees Ruth, learns more about her story, and shows charity to Ruth. He makes a special arrangement for Ruth so the immigrant woman can gather grain in his field. In doing so, Boaz obeys the Torah's explicit command to show generosity to the

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[8] Lacocque, André, and Kenneth C. Hanson. Essay. In *Ruth: A Continental Commentary*, 55–56. Minneapolis: Fortress Press, 2004.

[9] James, Elaine T. "Land and Community in the Book of Ruth." *Rooted and Grounded: Essays on Land and Christian Discipleship. Eugene, OR: Pickwick Publications* (2016): 29-39.

immigrant and the poor.[10] Boaz is so impressed by Ruth's loyalty to Naomi that he prays that God will reward her for her boldness. When Ruth comes home that evening, Naomi learns that Ruth met Boaz. Naomi is excited, saying that Boaz is their family Redeemer.

The family Redeemer was a cultural practice in Israel. If a man in the family died and left behind a wife, children, or land, it was the family redeemer's responsibility to marry that widow, taking up the land and protecting the family. When Naomi calls Boaz a Redeemer, she hopes her family has a future.[11]

In chapter three, Naomi and Ruth plan to gain Boaz's attention. Ruth stops wearing the clothes of a grieving widow; by doing this, she lets Boaz know she is available to marry. Ruth meets Boaz on the farm that night while Boaz is still asleep, and as she approaches, Boaz wakes up. Ruth takes this opportunity to clarify her intentions; she asks if Boaz will redeem Naomi's family and marry her. Once again, Boaz is astonished by Ruth's loyalty to Naomi and her family.

The redemption story is marked with presumed sexual tension and the possibility of illicit encounters in the middle of the night. It is tempting to wonder what exactly occurred between Ruth and Boaz in the late evening. Does the statement that Ruth "uncovered his feet" imply sexual activity or is it nothing more than a direct statement with no more depth than is stated?[12]

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[10] Pava, Moses L. "The Concept of Economy in Judaism." *The Concept of Economy in Judaism, Christianity and Islam* 9 (2022): 1.

[11] Jon Nielson, and Ian M Duguid, *Esther and Ruth: The Lord Delivers and Redeems*. (Phillipsburg, NJ: P&R Publishing, 1999).

[12] Jack M. Sasson, *Ruth: A New Translation with a Philological Commentary and a Formalist Folklorist Interpretation* (Sheffield, England: Sheffield Academic Press, 1995).

Believing Ruth to be a woman of honorable character, Boaz tells her to wait until the next day. He then agrees to redeem Ruth and Naomi before the town elders legally. Ruth returns to Naomi, and they are astonished at what has transpired and what will take place soon. These two women see their lives changing for the better.

In the final chapter, as things begin to look up for Ruth and Naomi, they face discrimination from one of their relatives. Boaz learns about a family member closer to Naomi than he is. This man is willing and eligible to redeem the family at the last minute. Nevertheless, he declines to do so when he learns he must marry Ruth, the Moabite woman. Boaz knows Ruth's loyalty, so he buys Naomi's family property and marries Ruth. Ruth's great act of loyalty that followed the opening tragedy is now matched by Boaz's act of loyalty, which leads to the family's final restoration.

Blessings are pronounced upon Boaz and Ruth, his new wife, and the text then turns to the birth of their son named Obed. The importance of this child is multi-faceted. He is said to be the grandfather of David, who would be king.[13] This story reverses all the tragedies these women endure from chapter one. The death of Naomi's husband and her sons is reversed, as Ruth is married again and gives birth to a new son. This new situation grants joy to Naomi; she is no longer Mara. The new baby is imagined sitting on the lap of Naomi, and the text refers to Obed as "Naomi's son." The story that begins with Naomi's suffering ends with her redemption.

The closing of this beautiful story carries multiple levels of meaning. The moralistic value of sacrificial love is the most frequently taught. Ruth's actions toward

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[13] Fuchs, Esther. "Status and role of female heroines in the biblical narrative." *Mankind Quarterly* 23, no. 2 (1982): 149.

Naomi and Boaz are understood to be first-order examples for others to follow. Likewise, the righteous character of Boaz is emblematic of the man who walks uprightly with the Lord. Additionally, the providence of God, while not explicit in the narrative, is seen through the "coincidences" that follow Ruth.

Among the many rich layers of meaning, using the text of Ruth 1:20-21 has some similarities to my context. That text says, "Don't call me Naomi, she told them. ‘Call me Mara because the Almighty has made my life very bitter. I went away full, but the Lord has brought me back empty. Why call me Naomi? The Lord has afflicted me; the Almighty has brought misfortune upon me."[14]

One similarity is that of women trying to find their way as immigrants, having taken a journey to improve their situation.[15] Throughout the COVID-19 pandemic, my ministry context suffered significant loss. Sadly, the conversation about mental health has been historically considered sensitive within the faith community. In some cases, mental illness is blamed on the devil. In other cases, God is blamed for the struggle people face. The congregation of Bound Brook United Methodist Church has found that many church members struggle with mental health issues that require professional treatment or counseling.

In this redemption story, Naomi could be going through some depression. She was an immigrant woman who suffered many losses. Naomi's tragedy makes her think that God is punishing her, but the story is about God's mission to restore Naomi and her family. Many people who attend church feel that when something goes awry in their

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[14] *Holy bible: New international version*. Grand Rapids, , MI: Zondervan, 2005.

[15] Karen González, *The God Who Sees: Immigrants, the Bible, and the Journey to Belong*, (Harrisonburg, VA: Herald Press, 2019), 12

lives, that God must be punishing them. Some of them may believe that God does not hear their prayer. When going through dark times, they may feel abandoned and alone.

Nevertheless, in this story, Naomi is never left alone, even when she tells her daughters-in-law to leave her alone. Ruth steps up and follows Naomi in her struggles. Ruth could be an example for the Church of today. The Church should be the place where a community that is suffering from mental illness finds a companion. Ruth demonstrates most of the functions or elements that a church or its pastoral leadership needs to be doing in the community, which is suffering and broken.

Depression is frequently overpowering human anguish caused by loss of goals, careers, families, and health.[16] Those who are depressed have comparable symptoms. They share Naomi's blindness to the people and the blessings in their lives. Bitterness can develop through chronic unhappiness, and bitter individuals are seldom enjoyable to be around. They can frequently drag down the persons trying to save them from drowning.

People may have occasionally thought like Naomi. They have faith in God's omnipotence, just like a devoted Christian would. Nevertheless, they lost sight of his lovingkindness somewhere along the way. They are upset about something—God, their situation, how someone treated them—or all three.

The way Naomi is arguing is not logical. Her rant is a sensitive one. She is posing ludicrous impossibilities while also answering her rhetorical questions. She has been crying out against God for the past ten years, her words laced with bitter sarcasm. She is expressing her sorrow because she lost her husband and two sons. Being separated from

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[16] Karp, David Allen. *Speaking of sadness: Depression, disconnection, and the meanings of illness*. Oxford University Press, 2017.

her cherished daughters causes her grief. Her tirade is oddly based on love, in any case. She understands the widow's predicament to be hopeless. She has few rights because she does not have a husband or sons in a world dominated by men. She has lost faith in herself but still has faith in her daughter-in-law. She pushes her daughter-in-law away from helplessness, hopelessness, loneliness, and abandonment.

Grieving and sorrowful people frequently express their emotions through their words. The Church needs to be able to spot when this is taking place. The Church must carefully and gently return the person to a proper understanding of God rather than immediately rebuking or addressing incorrect theology.

Today, there is a booming global movement for mental health, and the global Church is starting to acknowledge mental health issues as a top ministry priority. Mental health issues are the leading cause of disability worldwide, more disabling than conditions like heart disease, stroke, or diabetes.[17]

Most of the time, various elements, such as the family environment, biology, personality, spirituality, and challenging social circumstances like poverty and violence, combine to cause mental health problems. The effects of traumatic experiences like child abuse, interpersonal violence, or natural disasters are now widely acknowledged as key contributors to mental health issues.[18]

Thousands of people with mental health issues are branded, viewed as spiritually lacking, and occasionally, in the case of major mental illness, locked up and even chained

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[17] "Manage Your Mental Health," Barbara Bowes, Winnipeg Free Press, May 2, 2020, https://www.winnipegfreepress.com/business/2020/05/02/manage-your-mental-health

[18] Benjet, Corina, Evelyn Bromet, Elie G. Karam, Ronald C. Kessler, Katie A. McLaughlin, Ayelet M. Ruscio, Vicki Shahly et al. "The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium." *Psychological medicine* 46, no. 2 (2016): 327-343.

in institutions where they are exposed to poor living conditions, sexual and physical abuse, and neglect due to the church and secular society's failure to pay attention to this crucial issue.[19] Health care is worse, human rights are less respected, and mortality is higher for those with mental health issues. For the Church worldwide, persons experiencing mental health issues make up one of the most significant mission fields.

In the meantime, the Church should be tackling the new challenges the world is facing, be they emotional, spiritual, mental, or physical. Work should be holistic, involving the mind, body, and soul. Naomi had an immigrant story; she traveled to a new land for a better life. Her family initially found what they were looking for. They started forming new families; Naomi and her family seemed happy until tragedy struck her three times—the emotions of losing her family and the shame of returning empty-handed to her home country. Naomi deals with her feelings, naming her bitterness, and blames God.

Unfortunately, mental health is a new frontier the Church is facing. Nevertheless, going into the future and tackling mental health can be an exciting proposition. When we walk with God, the future of the Church is unstoppable.

In reading over the accounts of Ruth and Naomi, we learn as we walk next to a middle-aged woman of God who is depressed and angry over losses or as we walk by ourselves and feel like a burden to those who are with us.[20] Like Naomi, the Church might not be experiencing the future we expected or assumed we would. Like Naomi, we

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[19] Alexander, S. P., and J. F. Neander. "ADRENOCORTICAL RESPONSIVITY TO ELECTRIC SHOCK THERAPY AND INSULIN THERAPY: A Study of Fifty-Six Mentally III Patients in Rockland State Hospital, Orangeburg, NY." *AMA Archives of Neurology & Psychiatry* 69, no. 3 (1953): 368-374.

[20] Kelly Minter, *Ruth: Loss, Love & Legacy* (Nashville, TN: Lifeway Press, 2009), 14

might develop depression, exacerbated by the solitude we seek as we eject individuals who would bother us with their presence.

Nevertheless, even when it seems like there are no ways out of the suffering, returning to the community and accepting new family and intergenerational connections can help us get to a place where the pain is lessened, the life is regenerated, and there is a cause to keep going.

Instead of celebrating those who do not rely on others or seek to participate in their lives, contemporary secular and religious culture should work to reassert meaningful connection among children and youth in their young lives at the heart of family and community life. We are constantly told that maturity means not burdening one another, whether we are baby boomers, young people, people in our midlife, or older. We are taught that enduring suffering and loneliness alone while only finding joy in risk-taking and competitive endeavors signifies dignity and achievement.[21]

However, because communities' matter, praising the development of strong, admirable, and sometimes unconventional families and communities of many generations that can share joys and sorrows is an important step in addressing one of the fundamental causes and precipitating factors of severe depression. Clinically and spiritually, we are saved when we figure out how to stop leaving one another in the cold on lonely routes to suffering and when we figure out how to welcome others into the warmth of truly belonging to families and communities.

The only direct reference to mental illness in the Bible is found in Deut. 28:28, "The Lord will strike you with madness and blindness and confusion of heart." In this

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[21] Edward Fay Campbell, and William F Albright, *Ruth Anchor Bible* (New Haven, CT: Yale University Press, 2007), 31

instance, God forewarned the Jews against disobeying him and turning to Canaanite deities. Rebellion would have a variety of effects, including mental disease."

This sobering verse was played out in the life of King Nebuchadnezzar in Dan. 4:31-32: "O King Nebuchadnezzar, this message is for you! You are no longer ruler of this kingdom. You will be driven from human society. You will live in the fields with the wild animals, and you will eat grass like a cow."

Although God's humbling of a community or an individual can directly impact mental illness, living on earth can also cause it. A person's chemical makeup can be out of balance, just as a person's body can be physically ill. Trauma can lead to the development of mental illness. For example, Naomi mourned the loss of her husband and sons. She went home with her daughter-in-law Ruth after becoming homeless and trapped in a distant country. The effects of life and sadness on Naomi were so significant that the locals barely recognized her.

People have fought mental diseases ever since humanity fell. The Bible is filled with people suffering from depression, anxiety, and other mental illnesses.

Elijah: Since Elijah slew the prophets of Baal, Queen Jezebel offered him a reward. In his flight out of fear, Elijah cried out to God, "I have had enough, Lord. I am no better than my forefathers; please take my life."[22] 1 Kings 19:4. Elijah remained profoundly depressed and unable to care for his basic needs for 40 days and nights in this devastated state.

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[22] *Holy bible: New international version*. Grand Rapids, MI: Zondervan, 2005.

David, a man after God's heart, endured being treated as the least important of his father's sons, experiencing threats from the king to whom he had been obedient, and then experiencing betrayal by his son. David composed several mournful hymns that express his suffering and depression, such as Psalm 6:6-7, "I am worn out from my groaning. All night long I flood my bed with weeping and drench my couch with tears. My eyes grow weak with sorrow; they fail because of all my foes."

Martha: Overcome by her hostess responsibilities, Martha became enraged with her sister because she chose to sit at Christ's feet rather than assist in preparing food for the visitors. Martha finally approached Jesus, distressed. "Lord, do you not care that my sister has left me to do all the work by myself? Tell her to come and help me." The Lord answered her in Luke 10:40-42 "Martha, Martha, you are anxious and upset about many things, when only one thing is necessary."[23]

God has a particular concern for those who are weak and marginalized. We can find proof of this all over the Bible. We can see that God is serious about this from the very beginning of the Torah delivered to Moses. God's fervent request for protection for those who are weak and on the periphery of society—the foreigner, the widow, and the orphan can be found in Ex. 22:21–24. The prophets' condemnation of wrongdoing frequently had a two-pronged effect. When the prophets accuse Israel or Judah of wickedness, it is because of worshiping other gods and not loving their neighbors, as well as oppression.[24]

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[23] *Holy bible: New international version*. Grand Rapids, , MI: Zondervan, 2005.

[24] Jensen, Joseph. *Ethical dimensions of the prophets*. Liturgical Press, 2006.

Gleaning is a behavior mandated by Deut. 24:19–22 as one of the ways God invites the people of Israel to care for those who are weak and on the outskirts of society. Regarding harvest time, God did not want farmers to be productive. Grain, olives, and grapes that are left over should be given to the widow, the orphan, and the immigrant. Naturally, the narrative of Ruth makes extensive use of this approach.

Taking care of those who are weak and on the fringe of society in our midst is still our obligation and our duty. In our society and communities, who are they? Even widows and orphans can still be at risk. However, we can also mention individuals who are homeless, have mental health issues, consume drugs, or experience domestic violence.

God's call to action can manifest itself in as many different ways as there is help. The Church may offer desperately needed resources, support the pursuit of justice, and offer consolation. Empowering those who are weak and respecting the worth of every child of God are two important guidelines. We should all aspire to be like Ruth regarding our love, loyalty, and faith. Nonetheless, whether or not they exhibit these excellent character traits, our God-given duty is to assist those weak and on society's periphery.

God's prevenient Grace is seen throughout the Book of Ruth. Grace comes from the Greek “charis,” which means "gift." God gives us the gift of a relationship that encompasses salvation, peace, and eternal life through the person of Christ. According to United Methodist doctrine, only one Grace has multiple facets.[25] We use several adjectives to characterize the experience of Grace, such as prevenient, justifying, and sanctifying, depending on where we are in our spiritual journey. We can observe all three

[25] Christopher Payk. Grace First: Christian Mission and Prevenient Grace in John Wesley (Toronto, Ontario: Clements Academic, 2015),71

facets of God's Grace in the book of Ruth, drawing attention to Prevenient Grace.[26] The Trinity, one God in three people, and the essence of Grace, one Grace experienced in multiple ways, are both mysteries. There is both unity and diversity in God's Grace.

The term "prevenient grace" refers to God being with us always. From the moment we begin to exist to the moment we accept the relationship God offers us in Christ for ourselves, this Grace is most obviously at work from conception through conversion. While Ruth lived, it would be up until the point when we accepted the relationship that God provided us. Prevenient is derived from the Latin *praevenire*, which means "to come before." It refers to the Grace that precedes any human choice or activity in Christian theology. Prevenient Grace operates without our knowledge.[27]

God's love is courting us as a bridegroom court his wife. God's will is what attracts us. Prevenient Grace refers to God's desire to pursue us throughout our lives to bring us into a relationship with God and God's unwavering love. God's gift sets us free so we can accept his offer of a relationship and put our faith in Jesus Christ. That is God working in and through us, giving us spiritual power.[28]

Even more, than we want a relationship with God, God longs for one. This Grace is a covenant-based love connection. The Bible describes a covenant as the most powerful type of partnership. The prophets urged the Jews to rekindle their true

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[26] James, Carolyn Custis. *The gospel of Ruth: Loving God enough to break the rules*. Zondervan, 2008.

[27] William H Willimon, *Why I Am a United Methodist* (Nashville, TN: Abingdon Press, 2010), 28

[28] Rogers, Charles Allen. *The concept of prevenient grace in the theology of John Wesley*. Duke University, 1967.

relationship with God repeatedly—one of love and submission. They announced that a new covenant between God and the people would be formed.

Our covenant is based on Grace and love. Divine love, love sought after, love found, and love given. It is not up to us to seek God; God takes the initiative to look for us. This divine initiative is Grace to us. Prevenient Grace overcomes our brokenness and alienation.

Through the circumstances of Naomi's life journey—good and bad—prevenient God's Grace is demonstrated in the story of Naomi. The problems, disappointments, challenges, and suffering associated with losing a loved ones can serve as a platform for God to speak to our minds and hearts. Music, art, and the beauty of a place we feel at home can all be ways the Spirit communicates with us. With the love and sacrifice of others, such as Ruth, her daughter-in-law, family, and friends, Naomi can experience God's prevenient Grace.

We acknowledge God's generosity as a United Methodist church that serves the marginalized. Our community is interconnected. Loving God and neighbor is the motto of the United Methodist Church in Bound Brook. Christ is the church's head, but the pastor and laypeople are equal partners in leadership. To learn how to be Christ in and for the world, we are connected by our internal structure, free choice, and the power of the Holy Spirit. In small groups, people develop their spirituality. We light the world with the love of God collectively as the body of Christ! Social holiness is a focus of our church.

Social holiness is the only kind of holiness there is.[29] John Wesley started our legacy of social justice; we are carrying it on, and we want future generations to continue it. We share the joy of the biblical story with the world in word and deed as defenders of the weak and marginalized; active participants in the work for restorative justice; environmental accountability; equality of access to the necessities of life—food, clothing, shelter, health care, and education—and to opportunities; political and personal freedom; the dignity and value of each person and all people; and creating a world of reliable relationships between people. Like Ruth and Naomi in the Bible, we are kind and generous. With great compassion, we provide a helping hand to those in need.

The scriptures tell us to seek out and welcome everyone who wants to know and love God—the wealthy and powerful. As a church, it is ingrained in our very being to prioritize inclusivity and diversity, reaching out beyond the church's four walls to meet people where they were, empower them as individuals and as God's beloved children, and then send them out to continue proclaiming the happy news of God's love.

The leadership and membership of the United Methodist Church in Bound Brook make holy promises to God and the community, and they pledge to uphold those promises by being held accountable. By taking these oaths, we affirm that we will accept God's free gift of freedom and power to turn away from evil; that we will confess Jesus Christ as our Lord and Savior; that we will hold fast to the Christian faith as it is revealed in the Bible; that we will live a Christian life; and that we will obediently participate in the church's ministries by way of our prayers, our presence, our gifts, our service, and our

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[29] Irwin, Noel. "“There is no holiness but social holiness”: John Wesley and Leviticus 19." In *Leviticus in Practice*, pp. 69-77. Brill, 2014.

witness.[30] These commitments are clear when you look closely at the Ruth and Naomi account. Prayers, there are many valid ways to pray.

We recite the Lord's Prayer together, joining the millions of Christians throughout history who have used those words to discover the grace of God. Nevertheless, when we silently pray, "Help!" to God in times of need, when we wait in silence for God's direction, when we express our rage at injustice when we act to correct wrongs, and when we extend compassion to a wounded world, we are also united with earlier generations of Christians. It is all prayer. God heard Naomi's cries for assistance. We are obligated by our pledge to use prayer as the cornerstone of our lifetime quest to imitate God, both as individuals and as the body of Christ. Having faith in the ability of the Holy Spirit to direct our words, work, and ministry is our loyal response to God's love through Christ.

We are present when we are engaged in a hobby or activity we enjoy, such as playing a sport since we give it all our attention. We committed to the church to be present, and that is its nature. We pledge to give the church's life, work, and ministry our entire attention; to listen intently; to participate enthusiastically; and to provide our joy, creativity, skill, abilities, and gifts to support the congregation in becoming more like Christ. When present, we connect with others in ways that strengthen our faith and foster a sense of community. In keeping with her promise to be with Naomi, Ruth shared the good and the bad times.

Our promise to be present does not end when we leave the church. We serve as Christ's body throughout the world. In all facets of our lives—work, leisure,

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[30] Church, United Methodist. *The book of discipline of the United Methodist Church 2016*. United Methodist Publishing House, 2016.

relationships, and ministry—we are required to give God our undivided attention. When we select the ideal gift for a loved one—often something personal—we experience the same satisfaction in giving as the recipient gets in receiving. A considerate present given with love strengthens a link of sincere affection. Consider our promise to obediently participate by providing our gifts in this manner. Growing a generous attitude is more important than giving tangible contributions of time, money, talent, ability, or spiritual force.

Our pledge encourages us to be receptive to the presence of God within and around us, to receive the free gift of God's love through the birth, life, death, and resurrection of Jesus Christ, and to joyfully give of ourselves to others while under the direction and power of the Holy Spirit. All our membership vows are tied to service. We will be inspired to generosity in spreading the joy of God's love with others when we are steadfast in prayer and truly present to God and one another. Extension of that sharing is our promise of service. The manifestation of God's love and power in us is seen in our service to others both within and outside the congregation—in our families, neighborhoods, places of employment, educational institutions, and communities. We do not serve because we must; God's abounding love fills our hearts with joy. No inquiries are necessary for us to see Ruth's assistance to Naomi. Ruth does this because she has a great deal of affection for Naomi. We are sent out to be the body of Christ in, for, and among the suffering world by God after receiving power, joy, and strength from him. God's love is demonstrated by us carrying out our promise of service.

In a courtroom, witnesses are required to give truthful versions of events. We have witnessed and tasted the changing love of God as members of the God family.

Giving a truthful account of the freedom and ability of God's love to change the world is how we choose to serve as a witness to the world. Our daily conduct and our proclamation of the good news of Jesus Christ to a hungry and hurting world serve as our witness to the world. Boaz noticed Ruth's personality since it was clear to everyone that she was trustworthy.

Even more than in the lightless space of depression, God is present. God also exhorts us to seek God out in the people around us and the situations we find ourselves in. It is perhaps the most challenging step, yet we do not go through it alone; God leads the way, walks by our side, and lives within us.

Examining the Ruth and Naomi account in greater detail, what may it look like for us to act with faith like Ruth if we are dealing with uncertain situations today? How do we hold fast to God, his word, and his people?

The story of Ruth does not end with her choice to stay with Naomi and act on her faith. Ruth keeps her commitment to Naomi and God once she is in Judah. Ruth must have been tempted in her grief to give up or to shut herself off from the scrutiny and criticism of others. However, she does not. The church should exhibit this characteristic with the children and youth of the church and community. We must be able to go with the church children and offer them, love.

Ruth is greatly devoted to Naomi and God. She complies with all of Naomi's requests and upholds God's rule. With courageous humility, Ruth sets out for a landowner's field to glean and collect what the harvesters have left behind. She never complains. She is not arrogant and does not care what people may think. Ruth abides by God's commandments and accepts what He gives. With the church dealing with children

and teenagers, patients and humility are needed from the church membership. Understanding that God will provide for us on our journey is necessary for this mission.

We may all relate to experiencing overwhelming suffering or being overwhelmed by the complexity of our circumstances. Ruth needed a comprehensive strategy for how to solve her issues by herself. Instead, she made the simple decision to act appropriately at every turn.

Ruth's devotion, her fearlessness, and her will to always take the next correct action in the face of extreme hardship were all blessed by God. In any case, Ruth will never realize the extent of what God accomplished through her. King David would be her great-grandson, and our Savior, Jesus Christ, would be born from her family line many years later. Imagine that a common widow from a foreign country's profound loss, suffering, and subsequent brave commitment helped to bring about the salvation of the entire globe.

We need to remember that God is with us now if we are going through a moment of extreme difficulty or sadness. Ruth's example of steadfast faith, commitment, and love should inspire us. Wherever we are, if we hold on to God and His promises, God will supply our every need. Let us rely on God's direction. Keep moving toward God's children, and God will take care of the rest.

CHAPTER THREE

HISTORICAL FOUNDATIONS

Tackling the subject of mental health should be relatively easy, as the issue has gained more vocal support in the United States of America through traditional media outlets as well as various social media platforms. However, it is still a subject with a stigma attached to it. Many people do not understand what mental health is, or how it could possibly affect them. This remains the case despite the efforts of celebrities and athletes to be forthcoming about their struggles. People like NFL hall-of famer and BYU graduate, Steve Young, tennis player Naomi Osaka, and singer/actress Lady Gaga have presented their mental health disorders to the public in an effort to increase others' knowledge and understanding of such issues.[1]

This paper examines some of the history of the knowledge and treatment of mental health in the Methodist Church, how the church faces this issue now, and how it can do more for it in the immediate future.

But before going back in time, a look at current statistics is necessary to emphasize how widespread of an issue mental health is in the general population. The

[1] "10 Celebrities Who Struggle with Mental Health." University of Utah Health | University of Utah Health, November 30, 2022. https://healthcare.utah.edu/healthfeed/postings/2017/04/celebs-mental.php.

National Institute of Mental Health (NIMH) gathered these statistics for 2020 in the United States:[2]

Mental illnesses include those that are diagnosable currently or within the past year; of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); and exclude developmental and substance use disorders.[3]

Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment.[4]

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.[5]

Prevalence of Any Mental Illness (AMI)

- In 2020, there were an estimated 52.9 million adults aged 18 or older in the United States with AMI. This number represented 21.0% of all U.S. adults.

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[2] "National Institute of Mental Health." *Definitions*, February 2, 2020. https://doi.org/10.32388/4rlgvb.

[3] Glass, Richard M. "Diagnostic and Statistical Manual of Mental Disorders (DSM)." *AMA Manual of Style*, April 1, 2009. https://doi.org/10.1093/jama/9780195176339.022.529.

[4] "National Institute of Mental Health." *Definitions*, February 2, 2020. https://doi.org/10.32388/4rlgvb.

[5] "National Institute of Mental Health." *Definitions*, February 2, 2020. https://doi.org/10.32388/4rlgvb.

- The prevalence of AMI was higher among females (25.8%) than males (15.8%).
- Young adults aged 18-25 years had the highest prevalence of AMI (30.6%) compared to adults aged 26-49 years (25.3%) and aged 50 and older (14.5%).[6]

Prevalence of Serious Mental Illness (SMI)

- In 2020, there were an estimated 14.2 million adults aged 18 or older in the United States with SMI. This number represented 5.6% of all U.S. adults.
- The prevalence of SMI was higher among females (7.0%) than males (4.2%).
- Young adults aged 18-25 years had the highest prevalence of SMI (9.7%) compared to adults aged 26-49 years (6.9%) and aged 50 and older (3.4%).[7]

The NIMH broke these statistics into smaller components reflecting how the numbers changed over age, gender, race, etc. But the statistics already quoted are sufficient to present a picture of how many individuals battle some sort of mental health issue. Taking the AMI statistic that 21% of the population suffers from a mental, behavioral, or emotional disorder and translating it to a church context, a 100-person congregation can expect that twenty-one of its members are struggling in this way. If that congregation serves a community of 5,000, there are likely 1,050 members of the community suffering as well. These numbers are significant.

There are no statistics on mental health from the beginning of the Methodist movement 250 years ago. However, it is something that John Wesley addressed in his

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[6] "National Institute of Mental Health." *Definitions*, February 2, 2020. https://doi.org/10.32388/4rlgvb.

[7] National Institute of Mental Health, "Mental Health Statistics 2020" https://www.nimh.nih.gov/health/statistics/mental-illness

journals and sermons. Besides providing insight into his theology, Wesley's discourses on mental health issues open a window to how the 18th century looked upon such matters.

First, it is important to understand that Wesley was rather sophisticated in his knowledge and perception of society in his day. Wesley lived during the Age of Enlightenment. Starting in the mid-1600s, the Enlightenment was a time of crucial scientific discovery and philosophical breakthroughs that involved society, religion, academia, and almost all aspects of Western civilization. The influences and effects of this age were global in scope. Even Wesley's development of Methodism can be linked to the impact of the Age of Enlightenment.[8] Tony Headley states:

> Wesley's treatment of 'anxiety-qualia'(depression) as religious predicament and physical disorder is instructive in terms of placing Wesley vis-à-vis the backdrop of Enlightenment Europe and its scientific and philosophical interests, which has been the subject of recent historical and theological scholarship related to Wesley. Wesley was a preacher and revivalist to be certain, whose emphasis on perceptible inspiration and the assurance of faith cultivated a global Protestant denomination, but he was also a curious thinker with a fondness for science and faith, steeped in the intellectual developments of the North Atlantic, early modern world.[9]

Wesley read widely on different subjects that interested him. Besides theology, he was deeply interested in science and medicine and all the discoveries going on in the world. His sermons and writings reflect the health knowledge current in his day.

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[8] Heitzenrater, Richard P, *The Elusive Mr. Wesley*, 2 Vols. (Nashville TN: Abingdon Press, 1984),73

[9] Headley, Tony. "Wesley and Depression." Church Health Development, 1999. https://churchhealthdevelopment.com/wesley-%26-depression.

Wesley had read George Cheyne's 1735 book, *The English Malady*, where Cheyne uses the term "nervous disorders"[10] to describe a particular, chronic malaise, which in his view had become widespread in early modern England. As Cheyne puts it, this refers to "a class and set of distempers, with atrocious and frightful symptoms, scarce known to our ancestors, and never rising to such fatal heights, nor afflicting such numbers of any other known nation."[11] Like Cheyne, Wesley also makes use of the term "nervous disorders" to classify the feeling of heightened fear felt by people on a regular (or chronic) basis without any apparent external cause. [12]

John Wesley kept abreast of discussions on what today would be mental health. It is evident that his ideas to help increase mental health are not too out of line with many concepts utilized today. He even advocated the possible use of electricity to help with some significant occurrences of these "nervous disorders." Wesley spoke of what we would call mental health problems in September of 1775:

> We know there are such things as nervous disorders. But we know likewise that what is commonly called nervous lowness is a secret reproof from God; a kind of consciousness that we are not in our place; that we are not as God would have us to be: We are unhinged from our proper center. Does not this imply, that a kind of faintness, weariness, and listlessness affects the whole body, so that he is disinclined to any motion, and hardly cares to move hand or foot? But the mind seems chiefly to be affected, having lost its relish of everything, and being no longer capable of enjoying the things it once delighted in most. Nay, everything round about is not only flat and insipid, but dreary and uncomfortable. It is not strange if, to one in this state, life itself is become a burden; yea, so insupportable

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[10] Cheyne, George. The English malady: Or, a treatise of nervous diseases of all kinds ; ... in three parts. ... by George Cheyne .. London: Printed for G. Strahan, 1735.

[11] Cheyne, George. The English malady: Or, a treatise of nervous diseases of all kinds ; ... in three parts. ... by George Cheyne .. London: Printed for G. Strahan, 1735.

[12] Cunningham, Joseph W, "Anxiety in the Wesleyan Spirit: A Core Theological Theme?" International Journal of Systematic Theology 23 (3) (2021): 352–69.

> a burden, that many who have all this world can give, desperately rush into an unknown world, rather than bear it any longer. [13]

Wesley speaks of depression as one who has experienced it. While most of Wesley's writings do not communicate a great deal of his personal feelings, his letters and correspondence with others do give some insight. It is difficult to determine if Wesley suffered from chronic depression, but certain moments in his life were very discouraging, and events weighed heavily on him. His difficulties with the Church of England and his trip to the American colonies affected him profusely. While both experiences greatly influenced the development of the Methodist Church, they also affected him physically and mentally.

When Wesley did address the physiological manifestations of depression, he discussed how such a feeling could tie directly back to God. Though he was versed in the current medical texts of his era, not much was known about mental health issues. A great deal of early thought on mental health asserted that a person suffered because he or she had moral shortcomings. This concept was widespread among ancient Greek and Roman philosophers as well as early Christian thinkers.[14]

The key term of such thought was "passions," and this word was:

> "used by all (philosophers) as means to link between inner mental activities and the way the body reacts to the outside world. We can see it as an obligatory element to conceptualize illness, disorder, and health regarding mental activities. Moreover, the comparison of early modern and ancient conceptualization of "passions" reveals a moral aspect. Pathology, the study of "the passions" whatever their definition was, enabled to refer to mental illness and health in

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[13] Gorman, Joe, "John Wesley and Depression in an Age of Melancholy," *Wesleyan Theological Journal* 34, no. 2 (Fall 1999): 196–221.

[14] Funkenstein, Amos, *Theology and the Scientific Imagination: from the Middle Ages to the Seventeenth Century* (Princeton, NJ: Princeton University Press, 1986), 31-33

> moral, ethical, and judgmental terms. Early Christian authors used it to construct new theories and praxes about mental health, while early modern psychiatrists used it to develop corporeal methods of cure.[15]

Wesley saw a direct correlation between the struggles of the mind and the body, though he always would bring the love of God into his discussions:

> As long as we dwell in a house of clay, it is liable to affect the mind; sometimes by dulling or darkening the understanding, and sometimes more directly by damping and depressing the soul and sinking it into distress and heaviness. In this state, doubt or fear, of one kind or another will naturally arise. And the prince of this world, who well knows whereof we are made, will not fail to improve the occasion, in order to disturb, though he cannot pollute, the heart which God hath cleansed from all unrighteousness. [16]

In his teachings, Wesley clearly acknowledged that nervous disorders were natural. He understood the limits of his knowledge of the subject and conceded that he used the term in a very general manner. He thought that the doctors of his day did the same, using "nervous disorder" to cover different conditions that they didn't understand. Wesley believed some nervous disorders came from God working on a person or because of sin, but he differentiated these occurrences from actual nervous disorders.

In his writings, Wesley showed he accepted that most nervous disorders were perfectly natural. Wesley described people manifesting a lowness of spirit or a heaviness. While he used "nervous disorders" as a wide net that covered many different mental problems, most of his work concentrates on lowness of spirit, which today would be called depression. Here is how he described the phenomenon:

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[15] Rotman, Youval. 2021, "Moral Psychopathology and Mental Health: Modern and Ancient," *History of Psychology, Special Spotlight Section: Mental Health in Historical Context*, 24 (1): 22–33.

[16] Gorman, Joe, "John Wesley and Depression in an Age of Melancholy," *Wesleyan Theological Journal* 34, no. 2 (Fall 1999): 196–221.

We sometimes say, "A man is in high spirits;" and the proper opposite to this is, "He is low spirited." Does not this imply, that a kind of faintness, weariness, and listlessness affects the whole body, so that he is disinclined to any motion, and hardly cares to move hand or foot? But the mind seems chiefly to be affected, having lost its relish of everything, and being no longer capable of enjoying the things it once delighted in most. Nay, everything round about is not only flat and insipid, but dreary and uncomfortable. It is not strange if, to one in this state, life itself is become a burden; yea, so insupportable a burden, that many who have all this world can give, desperately rush into an unknown world, rather than bear it any longer."[17]

It is a rather good description of depression that Wesley constructed, though the physicians and writers of the 1700s did not call it such. In the literature of that period, mental health issues fell under vague terms like "nervous disorders." It wasn't until the following century that psychology began as a science, and it took a long time before that science became accepted as part of the medical community. Given these limitations of context, Wesley showed insight in recognizing the condition as being as real as any other malady a person might have.

In his correspondence, John Wesley guided his followers and friends on how to achieve mental and physical health. For Wesley, this could all be achieved if a person exercised discipline in their daily routine. This idea dovetailed nicely with all of Wesley's spiritual teachings—Methodists were so named because they held to a definite method or

[17] Headley, Tony. "Wesley and Depression." Church Health Development, 1999. https://churchhealthdevelopment.com/wesley-%26-depression.

process to achieve a close relationship with Jesus Christ. Wesley habitually thought along these lines, so it was natural for him to treat all of life with that mindset.

Reading about what Wesley advocated about nervous disorders adds insight to the notion that Wesley looked at all of a person's life as organic, meaning that everything was connected. It was impossible to separate the physical, mental, and spiritual aspects of a person. Everything went together, and when treating one part of a person, it was necessary to pay attention to all three components.

He backed up this idea by advising on a person's everyday health practices, such as exercising and eating nutritious food. He advocated waking early as a method to help prevent illness, maintain health, and alleviate any mental health problems. Wesley wrote *Primitive Physick,* a book he put together out of his concern for the health of the poor. About the book, H. Newton Malony said Wesley:

> [B]ecame greatly concerned for the spiritual and physical health of the poor. He was deeply impressed with the few physicians who called for the prevention of disease through healthy living and who recommended time-honored, inexpensive methods of cure…Wesley was ahead of his time in his dietetic and hygienic recommendations. Over 200 years ago, Wesley dealt with each of the major concerns of health psychology and behavioral medicine.[18]

Here is a sample of Wesley's instructions:

> Observe all time the greatest exactness in your regimen, or manner of living. Abstain from all mixed, all high-seasoned food. Use plain diet, easy of digestion. And this as sparingly as you can, consistent with ease and strength. Drink only water, if it agrees with your stomach; if not, good clear small beer. Use as much exercise daily, in the open air, as you can without weariness. Sup at six or seven on the lightest food. Go to bed early and rise betimes. To persevere with steadiness in this course is often more than half the cure. Above all, add to the rest (for it is not labour lost) that old, unfashionable medicine, prayer. And have faith

[18] Malony H. Newton Jr., "John Wesley's Primitive Physick: An 18th-century Health Psychology," *Journal of Health Psychology* 1996, Apr;1(2):147-59.

> in God, who 'killeth and maketh alive, who bringeth down to the grave and bringeth up.'[19]

As mentioned earlier, Wesley drew heavily from George Cheyne's work, and the daily routine Wesley directed at others comes from Cheyne. Tellingly, Cheyne connected his regimen to morality, which is also part of Wesley's teachings. Much of Wesleyan thought revolves around self-denial, self-control, and moderation or abstaining from particular substances and practices. Since Wesley saw adhering to these principles as part of the act of sanctification, he very much believed that God was an integral part of the process.

His teachings often highlighted the limits of what he thought faith could do for the body's healing. In his sermon on heaviness, he wrote the following about nervous disorders: "[F]aith does not overturn the course of nature: Natural causes still produce natural effects. Faith no more hinders the sinking of the spirits (as it is called) in a hysteric illness than the rising of the pulse in a fever."[20]

Wesley also pointed out that heaviness—depression—was shared among all believers. He wrote that all Christians experienced it to varying degrees at one time or another. It didn't mean that a believer was no longer a child of God; he or she was still a believer who also possessed joy, hope, love, happiness, and peace. Wesley also acknowledged that depression (heaviness) could be circumstantial and brought about by persistent sickness, grief, or poverty. Today, that would be termed situational depression.

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[19] Arroyo, Joy L, "John Wesley's Empowered Regimen: Cultivating Health and Sanctification," *Wesley and Methodist Studies* (2021), 13 (2): 154–174.

[20] Headley, Tony. "Wesley and Depression." Church Health Development, 1999. https://churchhealthdevelopment.com/wesley-%26-depression.

Almost 300 years ago, John Wesley advocated remedies for depression that are used today: cutting down on caffeine, eating simple foods, not consuming too much meat, and getting outside into the fresh air as often as possible. Before the American Revolution, he even advocated using an electrical machine. Joe Gorman relates:

In his journal from November 1756, he writes: "Having procured an apparatus . . . I ordered several persons to be electrified, who were ill of various disorders, some of whom found an immediate, some a gradual cure."[21] What was the electrical machine? It was a wooden contraption with hollow glass chambers and a metal rod extending through it, which was turned by a screw. Its purpose was to jolt the body with electricity and to affect the nervous system. In his journal, Wesley mentions using it on himself and other willing subjects. Wesley believed that electricity was a helpful remedy for dealing with many physical problems, especially nervous disorders like anxiety and even depression, or lowness of spirit. Wesley was so intrigued by the concept of electricity and its medical application that, in 1759, he published a manifesto on the subject, called *The Desideratum: Or Electricity Made Plain and Useful*. This work was not his original. It was – by Wesley's account – an abridgement and redaction of contemporary writers on the subject, including Benjamin Franklin and Richard Lovett among others, whose experiments and theories impressed Wesley and justified his use of the electrical machine.[22]

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[21] Arroyo, Joy L. "John Wesley's Empowered Regimen: Cultivating Health and Sanctification." *Wesley and Methodist Studies* 13, no. 2 (2021): 154-174.

[22] Gorman, Joe, "John Wesley and Depression in an Age of Melancholy," *Wesleyan Theological Journal* 34, no. 2 (Fall 1999): 196–221.

While Wesley was ahead of his time in the field of psychology, he always brought mental illness back to God. Yet he did so differently than many of his predecessors before the mid-1700s. Prior to Wesley's day, a person who was depressed or acting crazy was understood to suffer because of God's will. Perhaps God was punishing them for sin. Throughout the early church and Reformation, God became the scapegoat for many unexplained actions.

John Wesley approached it differently, taking his cue from some of the physicians of his day. It is critical to remember that Wesley was directing his advice to Christians. They were always his audience, so he clearly wrote with them in mind. Thus, Wesley must acknowledge heaviness or depression as consistent with faith. He wanted the Christian community to understand that depression was real, but that it was not necessarily a punishment from God. He was careful to talk about the importance of faith in a way that did not override the body's natural inclinations.

In his *Thoughts on Nervous Disorders*, Wesley stressed that people could work hard to avoid a lowness of spirit by following his plan of healthy eating, exercise, and sleep practices. While some of his proposals are remarkably similar to what doctors advocate today, some were far afield. The most egregious example is Wesley's belief that less sleep was better; whereas today, we know that many people have mental hardships because of insufficient sleep.

Wesley positioned prayer and nurturing the love of God within a person as two critical factors in one's emotional and physical well-being. He went as far to say that a physician couldn't be competent unless he was an experienced Christian. Even though he

advocated physiological approaches to dealing with depression, reaching out in prayer to God and knowing his love was also necessary for someone to rise above the heaviness.

While contemporary literature provided adequate material to uncover Wesley's thoughts on mental health, it is somewhat limited in the direction today's Methodist Church is addressing mental health in the congregations and communities it serves. The exception is discussing the mental health of today's clergy. Joy Arroyo addressed this issue and summarized John Wesley's thoughts on how God worked into the mental health equation. She said her article would explain the:

> link through a practical theological exploration of contemporary clergy health problems and argue for the importance of focusing on divine and human cooperation in efforts to improve clergy health. Wesley believed that God's Spirit would demonstrate the importance of physical health, provide desire for pursuing health practices, and give the self-control necessary for continuing on this path. This approach necessarily infuses personal prayer and faith with wellness practices.[23]

Combining faith with wellness practices is not something totally shunned by most secular psychologists. For some patients, it is a way to help with healing or coping. This area is only beginning to be studied more intently now— 300 years after Wesley talked about it!

This brings this paper to where we are three centuries after John Wesley and his *Thoughts on Nervous Disorders*. As a church, there is much to do in channeling Wesley to help both our church members and those outside the church who struggle with mental health. Local church programs like ministries dealing with grief and addiction do exist often through association with other churches. For the most part, a church creates the program or runs one used by another organization. These are admirable but not sufficient

[23] Arroyo, Joy L, "John Wesley's Empowered Regimen: Cultivating Health and Sanctification," *Wesley and Methodist Studies* (2021) 13 (2): 154–174.

in the face of the vast number of people struggling with mental health issues. Any category of mental health—the prevalence of suicide among young people, for example—ought to urge the church to do more to address these genuine life and death issues.

The United Methodist Church does address mental health issues in its 2016 Book of Resolutions. The introduction reads:

> We believe that faithful Christians are called to be in ministry to individuals and their families challenged by disorders causing disturbances of thinking, feeling, and acting categorized as 'mental illness.' We acknowledge that throughout history and today, our ministries in this area have been hampered by lack of knowledge, fear, and misunderstanding. Even so, we believe that those so challenged, their families and their communities are to be embraced by the church in its ministry of compassion and love.
> John Wesley's ministry was grounded in the redemptive ministry of Christ with its focus on healing that involved spiritual, mental, emotional, and physical aspects. His concern for the health of those to whom he ministered led him to create medical services at no cost to those who were poor and in deep need, refusing no one for any reason. He saw health as extending beyond simple biological well-being to wellness of the whole person. His witness of love to those in need of healing is our model for ministry to those suffering from mental illness.[24]

The document details how the church can best address mental health under the sections of Healing, Congregations, Communities, Clergy Support, Legislation, and Seminaries. While it is excellent the church produced such a resolution, it is sobering to realize it did so only six years ago! What happened to mental health in all the years between Wesley and the 21st century?

As mentioned earlier, psychology became a science in the 19th century, but it went through many transitions over the decades and is continually evolving. Its subject matter is complex! The brain and how it affects one's emotions is almost as much of a mystery

[24] Book of Resolutions— 2016 https://umcdmc.org/ministries/mental-health-ministries/

now as it was 150 years ago. More is known now than in the days of Wesley and the early days of psychology, but it still seems like just a drop of water in the ocean.

Mental health problems were long regarded with stigma, mainly because they caused behavior that didn't have a quick and easy explanation. While asylums became a way to treat those with severe mental issues, they also allowed such people to be hidden away from the mainstream of society. It was easy to pretend that such conditions never existed, allowing families to escape the disgrace of having a member labeled as "crazy."

In addition to often amplifying the suffering of those locked away and forgotten, asylums did a further disservice by focusing attention on extreme mental behaviors. It took a long time to for the public to recognize that mental health problems existed before reaching the "crazy" level. Many smaller issues could be just as debilitating for an individual.

Most people did not understand mental health, and nobody except those who studied it seemed particularly interested. Even psychiatrists and psychologists had the label of "quacks," and the prevailing thought for so many years was if someone suffered from depression or social anxiety, they just needed a little push to get them out of it. Since people tend to fear what they don't understand, they often shunned those that had mental health issues. Joe Gorman summarizes:

> While some forms of depression are clearly biological in nature, it seems that mere change in human biology alone is not enough to account for the epidemic proportions of depression in our culture. What has changed so dramatically in the past century is not human biology, but psychology, for our way of viewing and responding to the vicissitudes of life has fundamentally changed. Several trends in American culture in the past eighty years have also left indelible marks on the American psyche: the loss of a sense of community, the loss of the solidity of the family, and the loss of faith in public institutions, such as church and government. The waning of these formerly solid establishments has left people few places to find meaning and orientation for their lives. Many have turned to self as an anchor

> for an empty soul. It is no surprise, then, the emotional crisis in which we find ourselves, for a self-rooted in mere biology, situation, and chance is less than adequately armed to withstand the emotional and spiritual rigors of life.[25]

In this context, the church is in a position to re-establish itself as one of those public institutions that people have lost faith in over time. While the UMC resolution on mental health is laudable, it is the responsibility of the churches to put some meat to the words. A church is part of a community. While the reputation of churches overall has suffered in the political news of late, a local church can still reach out and connect with the community where it resides and serves. It can do this in the area of mental health by harkening back to John Wesley.

As Robert Heinlein once said, "A generation which ignores history has no past — and no future."[26] There is much that the United Methodist Church can bring back into the church from its founder almost 300 years ago. For one thing, John Wesley was not afraid to talk about mental health, as he understood it in his day. He thought that the process of sanctification meant that the whole being came into play— body, mind, and soul. This is probably something that has not seen much light in contemporary sermons. The talk of Jesus loving us is prevalent, but clergy need to address more of the everyday issues people face, such as mental health.

After all, one of Wesley's strengths is he connected with people where they were. He addressed their problems and presented closeness to God as a solution. From his letters and sermons, Wesley seemed fearless. Like Jesus, he did not shy away from

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[25] Gorman, Joe, "John Wesley and Depression in an Age of Melancholy," *Wesleyan Theological Journal* 34, no. 2 (Fall 1999): 196–221.

[26] Gillis, Lee, and Simon Priest. "Therapy: Past, Present and Future." *Therapy Within Adventure*: 21.

people’s genuine issues. The answers might not be what the people wanted to hear, but Wesley and Jesus gave their solutions anyway.

Many subjects, including numerous scientific domains, piqued John Wesley's attention. John made eloquent remarks about "nervous diseases" in the middle of the eighteenth century. When we think of depression today, this phrase was used back then. The speaker mentioned a person's state when affected by such a disorder. One wonders if Wesley ever experienced it because he described it beautifully.

At the time, nothing was understood about mental disease. Science and religion viewed any mental disorder as the product of moral failings. Someone with a serious mental illness received treatment by being locked up. Wesley always incorporated the love of God into his discourses, but he perceived a clear connection between the mental and physical challenges associated with sadness. He confirmed that it was a natural occurrence.

John Wesley gave advice to his friends and followers on how to achieve both physical and mental health in his letters. Wesley believed this was all possible if one maintained discipline in everyday activities. This notion fits Wesley's spiritual teachings very well, given that Methodists were so-called because there was a set path for developing a close relationship with Jesus Christ. Wesley's brain was wired this way, so he naturally approached all aspects of life with that perspective.

Wesley did a great job analyzing mental disease, how it developed, and how to treat it despite the ignorance of his day. A United Methodist pastor cannot help but feel a little pride that the man who founded the Methodist religion took the time to consider the

issue carefully and tried to offer some wisdom and solutions. That led directly to this project and report.

Modern psychology's development aided in the improvement of understanding and potential eradication of mental health concerns. Here is a word of warning, in any case. This field of study is constantly changing and evolving. Our understanding of the brain and how our emotions, ideas, and mental attitude are related to and influenced by events, the absence of a certain chemical or chromosome at birth, and several other factors are still in their infancy. This science is not exact.

Wesley also set an example by using the current knowledge of his time to develop solutions and ideas as to how his followers should conduct their lives. The average United Methodist most likely does not even know the extent to which Wesley addressed depression or that it was something he ever discussed. Churches are always looking for a way to connect with today’s audience to get them involved with the church. It seems like a particularly effective way to open the door to providing ministries and services geared to mental health when you announce your church has been dealing with the problem for 300 years!

As in any undertaking, leadership and utilizing resources are key. Mental health is a delicate and evolving area of study. Just as Wesley used the knowledge of his day, so must any church making a foray into helping those with mental health issues. Many government, medical, and nonprofit resources exist, so a church doesn’t have to reinvent the wheel.

A church can choose how far It wants to take its mental health advocacy. The United Methodist Church needs to share what is working in its various churches in order

to offer a template of what is effective. Pastors need to take the initiative to start conversations about mental health programs in their churches.

However, the most important thing that churches can all do is to take a page from John Wesley and begin to talk about mental illness. Let members know that it is a problem, explain the different manifestations it takes, and stress that there is no shame in it. Mental illness can affect anyone, and there is help to deal with almost any situation. John Wesley was not afraid to talk about it and offer solutions— why should today's Methodist Church be any less fearless?

Those with mental illness issues must be encouraged to access, participate fully, and be included in church activities. Most congregations are not prepared for inclusive ministry with individuals with impairments regarding mental illness and disability. With a lack of financing, there is a dearth of instruction and materials that adhere to our Wesleyan principles and notions of God's love and grace being open to all. Barriers in the church frequently prevent or exclude those who have mental illnesses and impairments, as well as their families. When persons with mental illness and disabilities are absent, along with their God-given talents, our churches fall short of what they could be.

In terms of mental illness and disability, the United Methodist Church of Bound Brook's mission is to guide the congregation in fostering a culture where those who are affected by mental illness and disabilities are fully included in all facets of worship, leadership, ministry, and mission through advocacy, education, and empowerment.

The United Methodist Church of Bound Brook will seek to provide pertinent materials and training through this initiative to prepare churches and other organizations for ministry with people who have mental illness and disabilities as well as their families.

CHAPTER FOUR

THEOLOGICAL FOUNDATIONS

We must equip the local congregations to help children and youth who suffer from mental illness inside and outside the church. As we become more aware of the scope of mental health issues, the church must develop tools to be better partners in the healing process. As believer in Jesus Christ, we are all called and given authority to care for one another. In First Corinthians 12:12-27 we are reminded, "All believers are members in the body of Christ, ever member is important, and no individual is more important than another."

Every child's journey to adulthood is complex. It's hard for a child to reach developmental and emotional milestones, learn healthy social skills, and deal with many problems at a young age. Also, children face added difficulties that sometimes do not have much to do with them. The entire situation becomes compounded because the current generation of children and youth face unique challenges that they must navigate.

This theological foundation paper will dialogue with liberation theology. Liberation theology is a Christian theological approach emphasizing the liberation of the oppressed. Peruvian Catholic priest Gustavo Gutierrez coined the term in the early 1970s.[1] In certain contexts, liberation theology engages socio-economic analyses with

[1] Robert Mcafee Brown, *Liberation Theology: An Introductory Guide* (Louisville, KY: Westminster John Knox Press, 1993), 15.

social concern for the poor and pollical liberation for oppressed people. It calls on Christians to liberate people from oppression.

It should come as no surprise that such a concept originated in Latin America, where poverty, racism, and social injustices are the norm rather than the exception. This approach to theology encourages Christians to engage the world around them with love and compassion. It also emphasizes that the Christian Church should advocate for justice in the name of God, not for political gain. In his writings, Gutierrez built a new spirituality based on solidarity with the poor and on the marginalized.[2] He also called on the church to assist in transforming current social and economic structures to advance social justice.

At first glance, liberation theology has little to do with mental illness. Yet this theological foundation paper will argue that the option for the lower classes speaks directly to the oppression of people with mental illness in the faith community. In this paper, the preferential option for helping those with mental health concerns who are less economically situated, which is a central concept in liberation theology, will be explored.

The United Methodist Church Book of Discipline describes the church's purpose as follows: "The mission of the church is to make disciples of Jesus Christ for the transformation of the world." [3]

Jesus commands his disciples, "And Jesus came and said to them, 'All authority in heaven and on earth has been given to me. Go therefore and make disciples of all

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[2] Rossa, Alberto, Gutiérrez Gustavo, et al, *The Theology of Liberation* (Manila, The Philippines: Historical Conservation Society, 1986), 25

[3] United Methodist Church, *The Book of Discipline of the United Methodist Church* (Nashville, TN: The United Methodist Publishing House, 2016), 33

nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit and teaching them to obey everything that I have commanded you. And remember, I am with you always, to the end of the age.'"[4]

First and foremost, the United Methodist Church affirms Romans 8:38-39, "Nothing can separate us from the love of God." Scripture calls us to bear one another's burdens. (Galatians 6:2) Our Social Principles remind us that "No person deserves to be stigmatized because of mental illness."[5] We believe that each of us must work to remove the stigmas around mental health. The United Methodist Church pledges to foster policies that promote compassion, advocate for access to care, and eradicate stigma within the church and communities.[6]

As United Methodists, we want a global connection, which means we must help deal with the world's problems. It is the strength of what we believe and who we are as Methodists. Churches are the best places to train strong disciples to deal with the different issues that confront people. Mental health is very much one of those issues, and since the local church is the primary place to bring about transformation in the world, we should start dealing with mental health concerns there. Working together as a church will highlight our strength in fulfilling our primary task of bringing the Good News to a broken world. Thus, Liberation theology works hand-in-hand with this mission and the task of the church.

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[4] Matt. 28:18–20, New International Version.

[5] *The book of discipline of the United Methodist church, 2016*. Nashville, TN: The United Methodist Publishing House, 2016.

[6] *Social principles of the United Methodist Church* (1992), Washington, DC: General Board of Church and Society.

Besides guiding us in having a personal relationship with his Father, Jesus gave us instructions to combat the ills of the world. Many of these were social injustices in his day, just as in ours. He told us:

> Then the king will say to those at his right hand, 'Come, you who are blessed by my Father, inherit the kingdom prepared for you from the foundation of the world, for I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me.' Then the righteous will answer him, 'Lord, when was it that we saw you hungry and gave you food or thirsty and gave you something to drink? And when was it that we saw you a stranger and welcomed you or naked and gave you clothing? And when was it that we saw you sick or in prison and visited you?' And the king will answer them, 'Truly I tell you, just as you did it to one of the least of these brothers and sisters of mine, you did it to me.'[7]

As a pastor in the Bound Brook community in New Jersey, I sit on several boards and agencies that work with public health initiatives including COVID-19 to increase awareness of public health information and build trust within the community I serve. This paper is the introduction to a project that calls for a radical shift in understanding how the church can bring mental health help to the community and improve health justice. It is a call for a more bottom-up approach to the health equity issue. It will require well-informed, responsible, and caring individuals who can recognize mental health problems and offer help and guidance for the person to follow. This approach to supporting the health and wellbeing of underserved and marginalized communities requires principles of liberation theology.

Paul Farmer is a medical anthropologist and physician who has spent more than 30 years at the forefront of global health equity and social justice worldwide. He uses the liberation theology lens for health care provision.

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[7] Matthew 25:34–40, (NIV).

Claudia E. Ordóñez, anthropologist and M.A. in Intercultural Relations, is Adjunct Faculty in the Hubert Department of Global Health, Rollins School of Public Health, at Emory University. She is proudly a Colombian immigrant and currently teaches at Emory and works in biomedical and public health research in the U.S. and South Africa. She wrote an article for Aquinas Emory Thinks entitled Public Health Needs Liberation Theology.

In this article, she highlights Paul Farmer and his organization, Partners in Health. She shares with the readers the three fundamental principles of liberation theology and how they connect to public health: structural violence, the preferential option for the poor, and accompaniment.

In Claudia E. Ordóñez's writing, she highlights Dr. Farmer's explanation on why it is essential that the poor need to be a priority in receiving health treatment:[8] A serious examination of epidemic disease has always shown that microbes also make a preferential option for the poor. A too recent example is how the ongoing COVID-19 crisis provides an excellent illustration of why this perception is so vital in medicine and health care.

From early on, COVID-19's mortal victims in the U.S. have been disproportionally members of historically and systematically marginalized and discriminated communities. Impoverished African Americans, Indigenous Americans, and Latinos died due to COVID-19 at disproportionately high rates compared to white

[8] Claudia Ordóñez, "Public Health Needs Liberation Theology," Aquinas Emory Thinks, February 16, 2021, https://aquinasemorythinks.com/public-health-needs-liberation-theology/.

people under 65. To be precise, the death rate for African Americans and Latinos has been 2.8 times higher than that of white people during COVID.[9]

Keep in mind that poverty is a complicated issue that cannot be boiled down to economics alone. These other issues include detrimental socialization and practices, stigma and discrimination, and a lack of access to healthcare options. However, poverty remains the most important indicator of poor health. The most vulnerable among us will undoubtedly pass away before their time, even if they have access to high-quality medical treatment.

Everyone has the right to health, but for health justice to prevail, we must first apply the principle of health equity, in which help is distributed according to communities' historical and current needs.

In Claudia E. Ordóñez's article she writes, "As lawyer and social justice activist Bryan Stevenson has said, 'The opposite of poverty is not wealth; the opposite of poverty is justice.'" Institutionalizing unjust conditions and behaviors such as poverty, racism, gender inequality, homophobia, and xenophobia result in structural violence.[10]

Health is significantly affected by life experiences and socialization processes. Dominant social and political structures and values also impact it. The current status quo results from a long history of racial and ethnic discrimination, sexual violence, and systemic violence. As a result, many of our institutions are structured in ways that promote these forms of institutionalized injustice. The church is not immune.

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[9] Claudia Ordóñez, "Public Health Needs Liberation Theology," Aquinas Emory Thinks, February 16, 2021, https://aquinasemorythinks.com/public-health-needs-liberation-theology/.

[10] Johan Galtung, "What Is Structural Violence? What Does It Mean?" TRANSCEND Media Service, May 28, 2018, audio, https://www.transcend.org/tms/2018/05/what-is-structural-violence-what-does-it-mean/.

It's critical to point out that many factors contribute to poverty. It's a complex situation involving individuals and institutions like churches. We can't just focus on institutions but also on individuals, who are the products of institutions. The unequal, unjust social arrangements that result in the lack of safety nets for the sick, unemployed, underemployed, and uninsured are unfair. It is no coincidence that in New Jersey, one of the central populations dying of COVID-19 is low-paid workers, employed without any work benefits and often undocumented.

Accompaniment is another fundamental principal Farmer emphasizes in his approach to those who are underserved and marginalized in health care. Community engagement is imperative for the meaningful engagement of communities. It's also proved vital in my relationships and experiences with African American and Latino/Hispanic community members. In recent decades, the desire for accompaniment in community engagement has been highlighted as the feelings, wants, and needs of underserved and marginalized communities in this country have received more attention.

Carrying out this act of solidarity requires a person to be sincere, compassionate, empathetic, and respectful. Liberation theology demands allyship— a consistent process of building relationships of consistency, trust, and accountability with ostracized individuals and/or groups of people. An ally goes above the call to ensure that people have their needs met and works to ensure that marginalized people have more resources.

Historically, mainstream society has not treated African American and Latino (Hispanic) communities well. Those groups are therefore suspicious of outsiders who have traditionally used and abused them. They want to claim and exercise their agency

and self-determination, empower themselves and their leaders, and be supported by those outsiders or allies who genuinely care.[11]

A prerequisite for accompaniment is cultural humility, which enables one to see a person in a different light and to see that person as part of the larger community. It's important for the would-be accompanier to acknowledge the harm a community has experienced from outsiders, as well as their desire to be a supporter of that community. It becomes necessary for a person to perceive themselves as a part of the community while taking up the position as a supporter of those who suffer mental health difficulties.

Awareness of the intersectional condition of human existence powerfully complements humility. It also allows for authentic accompaniment in the path to health justice. To fully comprehend how disadvantaged populations affect our collective health and wellbeing, we must first understand them. Long-term success cannot be guaranteed by the conventional public health approach, which views communities as "target populations" in need of a "formula" for improving their health in relation to one or more health issues. To communities, such an approach appears impartial. Addressing just one aspect of the system can only go so far, since it has interrelated and crossing sections. On the other hand, a strategy of accompaniment examines the whole system and works with communities to better it.

During this COVID-19 pandemic, our country has become increasingly divided over political and social topics. This pandemic has exacerbated issues in mental health, financial security, and relationships, to name a few. Clearly, coronavirus has affected everyone, and comprehensive action has addressed preventing the spread of the virus. A

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[11] *Ending Discrimination against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*, National Academies Press, 2016.

positive outcome of focusing on these historical injustices has been the proactive improvement of the quality of patient care for those who have historically received suboptimal care. Communities have been impacted tremendously by the COVID-19 crisis and the response from governments and healthcare institutions. These efforts to educate the public about their health show how the new focus on health justice is slowly making its way into health policy.

A perspective of Christian morality and ethics must be guided by Jesus' call to be proactive in loving our neighbors and helping them holistically as the whole they are. When everyone works together, we can hear and accept the call to practice charity, solidarity, and accompaniment in our work with people at the margins and beyond.

Recent national surveys of young people by the United States Department of Health and Human Services (HSS) show alarming increases in the prevalence of particular mental health challenges. HSS said:

> In 2019, one in three high school students and half of the female students reported persistent feelings of sadness or hopelessness, an overall increase of 40% from 2009. We know that mental health is shaped by many factors, from genes and brain chemistry to relationships with family and friends, neighborhood conditions, and larger social forces and policies. We also know that young people are subject to a bombardment of media and popular culture messages that erode their sense of self-worth, telling them they are not good-looking, famous, smart, or rich enough. Progress on legitimate and distressing issues like climate change, income inequality, racial injustice, the opioid epidemic, and gun violence feels too slow.[12]

This statement calls attention the double-edged effect of technology. While technology has improved lives in meaningful ways, such as accessing information, delivering resources, and increasing the ability to build new communities, its adverse effects are also felt. When technological tools are misused, they can reinforce bullying

[12] "What is Mental Health?" U.S. Department of Health & Human Services, MentalHealth.gov, November 10, 2021, https://www.mentalhealth. gov/basics/what-is-mental-health.

behaviors and encourage violence and exclusion, making our youth less safe and supported than they might otherwise be.

Young people had difficult situations to navigate at home, school, and the community, before the COVID-19 pandemic. Now their position is more vulnerable. The pandemic has affected their livelihood, financial security, mental health, physical health, and wellbeing.

Mental health issues are not an easy fix. They require patience and perseverance. Ensuring a healthy community will require a comprehensive approach that includes government policy changes and individual, family, and community-level actions.

A church must behave in ethically responsible ways. It does not just have a medical responsibility to act; it has a moral obligation to act. The United Methodist Church of Bound Brook fortunately come out of the COVID-19 pandemic with a more unified and connected community. The United Methodist church of Bound Brook got an incredible opportunity to rebuild a culture of care and compassion for each other. If we're willing to seize this moment and act with integrity, kindness, and love for the people around us, we can begin to lay the foundation for a healthy, more resilient, and more joyful church.

In her book, *The Disabled God: Toward a Liberatory Theology of Disability,* Eiesland illustrates how we can apply several vital concepts from Liberation theology to the medical field, including mental health.[13]

This pandemic is a reminder that epidemics always prefer the poor and the uneducated. The healthcare system is rarely successful at helping this segment of the

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[13] Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville, TN: Abingdon Press, n.d), 55.

population. If healthcare, educational systems, and non-governmental organizations created a special place to serve the lower class and the community, there would be unnecessary suffering. When the church commits to a preferential option for the lower classes, it becomes a healing tool for the people.

Mental health encompasses a person's emotional, psychological, and social well-being. It's an essential part of overall health. The 1999 Surgeon General's Report on Mental Health describes it as the "springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem."[14]

Simultaneously, mental health challenges can be difficult to define, diagnose, and address, partly because it is not always clear when an issue is severe enough to warrant intervention.[15] No matter a person's age, everyone sometimes feels frightened, worried, sad, or distressed. In most cases, these symptoms don't last for a long time. They don't affect how a person performs at work or other everyday activities. However, there are times the signs of mental health problems can cause severe difficulties in life, impacting one's ability to function in everyday life and relationships with others. These mental illnesses include schizophrenia, anxiety disorders, major depressive disorder, eating disorders, and bipolar.[16]

Mental health conditions are shaped by biological and environmental factors including genetics, brain chemistry, and life experiences. Sometimes mental health

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[14] "Report on Mental Health Released by US Surgeon General," Inpharma Weekly &NA, n.d., (1222): 4. https://doi.org/10.2165/00128413-200012220-00008.

[15] National Institute of Mental Health, *Mental health: A report of the Surgeon General* (Rockville, MD., 1999).

[16] "Mental Health Conditions: Depression and Anxiety," Centers for Disease Control and Prevention, April 23, 2018, https://www.cdc.gov/tobacco/campaign/tips/diseases/depression-anxiety.html

disorders occur in families, but multiple genes often shape them. When an individual develops symptoms, experiences and the surrounding environment can further modify them.[17]

Moreover, environmental factors can lead to significant issues, including alcohol or drugs during pregnancy, birth complications, discrimination, and racism. Unfavorable childhood experiences like abuse, neglect, living in segregated neighborhoods, and being surrounded by community violence are also factors. Children who experience adverse childhood events often have more complicated lives.

They are more prone to mental health problems, school dropouts, substance abuse, incarceration, and violence. These experiences could lead to the development of toxic stress. Stressful events during sensitive periods of brain development can lead to lifelong changes in the brain's structure, which can have lasting effects on behavior and mental health.

It is challenging to isolate biological and environmental factors that cause mental health issues. For example, suppose a child's genetic makeup makes depression more likely. In that case, the chances are greater the child is more likely to become depressed when confronted with an experience such as bullying.

Professor Rev. Dr. Michael Adam Beck wrote in his book *Painting with Ashes: When Your Weakness Becomes Your Superpower,* "The church should be a place where wounded people can come and be made well again, not with flashy miracles, but by

[17] "Redirecting," March 20, 2023. https://doi.org/10.1016/S0140-6736(12)62129-1.

finding a safe place where they can unbandage and bare their wounds in a community of love and forgiveness."[18]

The Church needs to be a place to heal the body, mind, and soul. People with mental illness need a place of hope and healing, and the church can provide the tools for that. In the Bible, healing and hope have always been part of the biblical story. The Holy Scriptures tell us when things went wrong. Chapter 3 of the Book of Genesis explains why there was a break in the relationship between God, the Creator, and his chosen people. The Bible relates tremendous brokenness: Cain killing Abel, Noah and the flood, to name a few. However, while we see brokenness, we see restoration as well.

In the midst of brokenness, God provides the opportunity for a clean slate for every individual and group on the earth. God gives healing and restoration to everyone. This healing and restoration continued through the Old Testament and into the New Testament, coming full circle in Revelation 21–22.

We see that God is committed to healing. God gives life as a gift and expects those who receive it to share it with others. Jesus sent the disciples out to provide healing and hope in the new community of believers.

Another fundamental principle of Liberation theology is structural violence. Poverty, racism, sexism, homophobia, and xenophobia are among the reasons that some people commit violent crimes. Structural violence is an old and familiar form of violence perpetuated by unjust social arrangements. As liberation theologians have long argued that the secular world must take a stand for the poor and otherwise marginalized so they

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[18] Michael Adam Beck, *Painting with Ashes: When Your Weakness Becomes Your Superpower*, (Plano, TX: Invite Press, 2022). 54

will have a chance to flourish. We all need to be free to express ourselves, be happy, grow, and help others.

If there is no safety net to help the sick and the frail, then it will not happen. There are a lot of problems with the world today, one of which is that our global capitalism cannot rid us of structural violence. However, understanding the construction of the various social constructs and the mystery of hope will help us navigate the world.

Divine Love is evident in concrete acts of partiality and preference. A traditional theological position says God loves all people. Fundamentally, the cosmological argument states that God's existence is necessary for anything to exist. Even though human history is predominantly about social divisions, political inequality, and painful injustice, God is always there. In those conditions, we tend to be selfish, greedy, and insensitive to one another.

God responds to specific situations of oppression and manifests His care for the victims of social misery by opposing injustice. This is not to say that God is against the rich or the powerful. Instead, God is for the poor, the weak, and those who struggle to create a more just and compassionate world.

As Eiesland states, "For many disabled persons, the church has been a city on a hill physically inaccessible and socially inhospitable."[19] Liberation theology for mental illness emphasizes the spiritual importance of the economic dimensions of mental illness oppression and its implications for poverty. People with mental illness are often denied social support and considered to have little social consequence. A growing collection of

[19] Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville, TN: Abingdon Press, n.d). 91

literature critiques the contemporary treatment of mental illness as being largely dehumanizing and oppressive.

Mental illness causes radical social change. It touches all aspects of society and has affected many people's lives for years. Mental illness liberation theology is a new approach to fighting for mental health care reform. It brings a different perspective that can lead to hope and conviction to begin alleviating the radical mental illness rights cause. People with mental illness need help, not separation from others.

Poverty, mental health, and mental illness are intertwined issues, but what constitutes mental illness in the poor is unclear. Poverty varies depending on the level of economic development and the role a social safety net plays in different communities. The 2022 Current Population Survey in the United States provides a clear example of the correlation between disability and poverty. According to the survey, 20.8 percent of all non-institutionalized civilians aged 18-64 who report a work-limiting health problem or disability are employed. [20]

I want to draw attention to a general theological trend that divides Liberation Theology into three areas: the Latin American experience (the poor), feminist theology (women), and black theology (Black people). This claim may be supported, among other things, by the idea that liberation theologies are more movements than new schools of theological theory, attempting to bring together religious and sociopolitical issues.

Liberation Theology emerged in the third world, where it was seen that one's praxis or life experience might have a significant impact on one's understanding of God and His action in the world. According to this perspective, the God worshipped in the

[20] United States Census Bureau, *2022 Current Population Survey in the United States*

barrios or slums of the main cities of nations like Peru or Brazil is quite different from the God of the wealthy.

The notion that one's place influences one's perspective on the Scriptures in life has long since gained ground in some communities in the United States, particularly among Latinos, Blacks, and women.

Liberation theology, regardless of how it is generally viewed, is challenged to pay close attention to context or experience and consider whether it is possible to apply theological truth using a specific historical situation as described in Scripture. Theology is challenged to find and form theological truth from a current context without discounting experience, tradition, reason, or Scripture.

Christians are urged by liberation theology to free those who are imprisoned. This idea was developed by a Catholic priest in South America, a region where social injustice, racism, and poverty are more common than not. This school of theology exhorts Christians to interact with the world lovingly and compassionately in relation to mental illness in the local church. The church must approach theology by showing compassion and love to children and young people struggling with mental illness. Those who struggle with mental illness are frequently the ones who are oppressed by social inequality and poverty.

I connected liberation theology to mental illness by observing that the less advantaged groups within a community frequently struggle with these conditions. They also have fewer resources available to them than the more affluent classes. They also frequently find themselves drifting to a church needing assistance because they have nowhere else to turn.

Liberation theology for mental illness strongly emphasizes the spiritual significance of the economic oppression caused by mental illness and its effects on poverty. Individuals with mental illnesses are frequently excluded from social groups and seen as having a little social impact. A growing body of writing criticizes the oppressive and essentially demeaning way mental illness is currently treated.

A church is expected to act morally. It has a moral obligation to take action in addition to its medical responsibility. According to Christian morality, Jesus calls us to be proactive in loving and serving our neighbors as the complete person they are. Together, we can hear and respond to the invitation to engage in acts of generosity, solidarity, and accompaniment in our work with those who are marginalized and beyond.

Access to, full participation in, and inclusion in church events must be encouraged for those with mental illness impairments. Most churches are unprepared for inclusive ministry with people with mental illness and disabilities. There is a shortage of training and resources that follow our Wesleyan values and ideas of God's love and grace being available to everyone due to a lack of funding. People with mental diseases and impairments and their families are regularly excluded or prevented from church activities due to barriers. Our churches are not as effective as they may be when people with mental illness and disabilities are present, along with their God-given gifts.

The United Methodist Church of Bound Brook's mission with mental illness and disability is to lead the community in cultivating a culture where those who are impacted by mental illness and disabilities are fully included in all aspects of worship, leadership, ministry, and mission through advocacy, education, and empowerment.

Through this initiative, the United Methodist Church of Bound Brook will work to provide churches and other organizations with the necessary resources and training to help them minister to people with mental illness and disabilities as well as their families.

Liberation Theology offers an incredible combination of hopeful patience and intolerance with the way things are. It focuses on the long historical and eschatological road to justice, but it's combined with a strong sense of urgency. Its tenets are the foundation for a church-based program that will reach out to those marginalized people in the community suffering from mental health, with an emphasis on young people.

CHAPTER FIVE

INTERDISCIPLINARY FOUNDATIONS

The church is ill-equipped to assist children and youth struggling with mental illness. Yet churches could be effective collaborators in the healing process if they could familiarize themselves with existing tools to resource congregations and the public.

The road to adulthood is different and difficult for each child and adolescent. At best, it is challenging to achieve developmental and emotional milestones, develop positive social skills, and resolve problems. The road in life is rarely clear, and there is no map to follow. Today's youth, however, face further challenges from poverty, social unrest to non-stable family structure. These problems can significantly harm their mental health.[1]

This final project addresses mental illness in children inside and outside the church, considering ways in which the church is often not in a viable position to help. The project hypothesizes that if the church could develop therapeutic tools, it could be a better partner in the healing process. This interdisciplinary foundation paper brings the field of family systems to bear on the hypothesis.

This chapter provides an overview of Murray Bowen's family systems theory. It will detail the main clinical components of the model and describe how he developed

[1] "Social Development," Office of Population Affairs, US Department of Human Health and Services, 2022, https://opa.hhs.gov/adolescent-health/adolescent-development-explained/social-development.

them. Its therapeutic process will be discussed, along with current model advancements. There is also utilization of some scripture from the Old and New Testaments that speak about the generational curse, a crucial factor in family system theories. Also explored are the main objections to Bowen's concepts, as well as a look into Jungian psychology. The reasons are that this project is based on the family systems theory which dovetails with the local setting connected to religious and historical traditions.

Murray Bowen's family systems theory, sometimes known as the "Bowen Theory," dates to 1974.[2] Although it has only garnered intermittent attention in other nations, family therapy is nevertheless heavily influential in the United States. Murray Bowen was born in Tennessee in 1913 and died in 1990. Trained as a psychiatrist, he initially used the psychoanalytic model in his practice by involving mothers in the examination and care of schizophrenia patients at the Menninger Clinic in the late 1940s. After moving to the National Institute of Mental Health (NIMH) in 1954, he broadened his interest beyond psychoanalytic study as he started to perceive families as systems rather than groups of individuals. At the NIMH, Bowen expanded the number of family members participating in his studies and psychotherapy sessions for schizophrenic patients.

Bowen moved to Georgetown University in 1959 and started the Georgetown Family Center, where he was director until his death. Here, he applied his growing theory to less emotionally severe issues. He deeply investigated multiple generations of families between 1959 and 1962. Bowen concentrated on what he believed to be the typical patterns of all "human emotional systems" rather than creating a theory about pathology.

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[2] Murray Bowen, *Family Therapy in Clinical Practice* (New York: Jason Aronson, 1978). 20

Bowen frequently said, “There is a little schizophrenia in all of us,” emphasizing the qualitative similarities shared by all families.[3]

Bowen’s research focused on the patterns that emerge to reduce anxiety in families. The feeling of too much proximity or distance in a relationship is a significant cause of worry in families. The level of current external stress and the sensitivity to particular themes passed down through the generations will define the level of anxiety in each given family. Persistent apprehension or reactivity can occur if family members lack the mental capacity to reason out their answers to relationship issues and instead frantically respond to perceived emotional demands. The main goal of Bowenian therapy is to reduce chronic anxiety by:

1. Facilitating awareness of how the emotional system functions; and
2. Increasing levels of differentiation, where the focus is on making changes for the self rather than trying to change others. [4]

Bowen built his approach on seven interrelated concepts, which are:

1. Emotional Fusion and Differentiation of Self [5]

2. Triangles[6]

3. Nuclear Family Emotional System[7]

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[3] Michael E. Kerr and Murray Bowen, *Family Evaluation: An Approach Based on Bowen Theory* (New York, NY: Norton, 1988). 34

[4] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[5] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[6] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[7] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

3a. Couple Conflict [8]

3b. Symptoms in a Spouse[9]

3c. Symptoms in a Child[10]

4. Family Projection Process[11]

5. Emotional Cutoff[12]

6. Multi-generational Transmission Process[13]

7. Sibling Positions[14]

This chapter will focus on two of the seven concepts, exploring the processes of family projection and multigenerational transmission. In family projection, children exhibit symptoms when they become entangled in the relationship anxiety of the previous generation. The child who feels the least emotional distance from their parents is the most susceptible to acquiring symptoms. According to Bowen, this happens when a child reacts anxiously to the tension in the relationship between the parents. This reaction is then misinterpreted to mean that the problem lies in the child. The child may get either more demanding or more handicapped because of this cycle of reciprocal anxiety. For example, a child's illness could prevent one parent from pursuing marital intimacy. As

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[8] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[9] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[10] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[11] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[12] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[13] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

[14] Murray Bowen, *Family Therapy in Clinical Practice* (New York, NY: Jason Aronson, 1978). 20

the marriage becomes less tense, both partners become committed to treating their child's ailment, which could develop into a chronic or psychosomatic condition. [15]

As with all of Bowen's structures, intergenerational projection is presumed to occur in all families to variable degrees. Which child is the subject of family anxiety and when it happens may be influenced by various intergenerational factors. Some children are more vulnerable than others, depending on the severity and timing of crises. According to Bowen, traumatic experiences are essential in emphasizing the family processes rather than "creating" them.[16]

The second concept I want to explore is that of multi-generational transmission. Bowen's theory explains how projection from parent to child transmits patterns, themes, and positions (roles) in a triangle from one generation to the next. Each child's impact will vary, depending on the degree of triangulation they experience with their parents.[17]

It is a hallmark of Bowen's theory that he considered at least three generations of a family when addressing a presenting symptom. The study of family patterns across time serves as a tool for intervention and evaluation, helping family members gain enough distance from their current struggles with symptoms to consider how they might alter their role in the generational transmission of anxiety. Bowen writes:

You can consider your role as an active player in interactions that repeat themselves by learning about your family and its history and understanding what made

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[15] R. Robert Creech, *Family Systems and Congregational Life: A Map for Ministry* (Grand Rapids, MI: Baker Academic, 2019), 127.

[16] Ronald W. Richardson, *Creating a Healthier Church: Family Systems Theory, Leadership, and Congregational Life* (Minneapolis, MN: Fortress Press, 1996), 171.

[17] Creech, *Systems,* 23.

family members unique, how they interacted, and where they got stuck. By doing this, you can stop viewing yourself as a passive recipient of your experiences and start thinking about it as a role you play.[18]

Unexpectedly, Bowen tended to downplay children's roles in his family treatment. While Bowen might engage children in the early stages of therapy, he would eventually dismiss them in favor of focusing on the adults as the family system's most powerful component.[19] A detangling tactic excludes a child from therapy responsibilities. Parents can start separating from one another when the child is no longer a "triangle person" to solve problems between them and the therapist refuses to play the replacement role.

Bowen's multi-generational model goes beyond the idea that the past impacts the present, arguing that that present family systems still engage in previous patterns of connection.[20] Therefore, the therapist asks questions to get clients to consider their current difficulty as well as how previous generations handled problems with close relationships. The therapist may inquire about how earlier generations dealt with grief, for instance, if death preceded the development of a symptom in the family. The purpose of the questions is to learn about both the values held by the family and how relationships changed due to the loss.

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[18] Creech, *Systems,* 24.

[19] Creech, *Systems,* 94.

[20] Brown, Jenny, and Lauren Errington, *Bowen Family Systems Theory in Christian Ministry: Grappling with Theory and Its Application through a Biblical Lens* (Neutral Bay, New South Wales, Australia: The Family Systems Practice & Institute, 2019). 100

It becomes more difficult for people to blame one another for personal failings if someone tracks symptoms and investigates related themes over at least three generations. As the therapist and family members see patterns that recur over generations, it is possible to recognize the "automatic" responses that family members have toward one another.

The complexity of Bowen's approach to family therapy makes it somewhat unique. The emphasis on emotional processes across generations and how individuals differ within their systemic context gives family therapists access to a multi-level perspective typically reserved for psychodynamic therapies. According to Bowen's model, the treatment process must somehow apply to the therapist's life for them to continue connecting to the client's family system. This model emphasizes the emotional contact between therapists and their clients.

Bowen's theory has met with critique from several quarters. Because many clients want to focus primarily on symptom reduction in the nuclear family, many Bowenian therapists acknowledge that his model's broader focus can have limitations.[21] Symptom reduction is only considered the foundation from which families can go forward less nervously toward working on detangling and improving degrees of differentiation.

Bowenian treatment has garnered support from prominent feminist therapists like Betty Carter and Harriet Goldhor Lerner but has come under fire from others. For example, feminist therapist Deborah Leupnitz notes that Bowen and other pioneers of

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[21] Jenny Brown, "Coming to Grips with Family Systems Theory in a Collaborative, Learning Environment. Bowen Family Systems Theory and Practice: Illustration and Critique*," Journal of Family Therapy* (ANZJFT) 20, no. 2 (1999): specific page number, https://www.thefsi.com.au/wp-content/uploads/2014/01/Bowen-Family-Systems-Theory-and-Practice_Illustration-and-Critique.pdf.

male family therapy have focused far too much on the mother's role in the development of a child's symptoms.[22]

A model like Bowen's encourages the woman to "back off" while placating and pursuing the distant male, claims the Women's Project in Family Therapy.[23] Betty Carter claims that because the model presupposes men's limits in terms of emotional engagement in therapy and family relationships, it is biased against women and dismissive of males. Reconstructing a therapy vocabulary of intimacy and attachment that is not misused to infer disorder is a continuing struggle for feminist Bowenian therapists.[24]

Another complaint stemming from the sexism of Bowen's "man-defined" terminology is that his therapy pays little attention to feelings.[25] Objectors claim that Bowen's treatment emphasizes being analytical and objective concerning emotional processes, which places the expression of emotions in therapy at a low priority. While Bowen emphasizes the goal of assisting the client in learning about their family's emotional processes, a client's motivation comes from their emotions in their relationships with their family of origin.

The family systems theory's main subject is the behavioral interactions between family members at every family gathering. The idea holds that family interactions

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22 Deborah Anna Luepnitz, The Family Interpreted: Psychoanalysis, Feminism, and Family Therapy (New York, NY: Basic Books, 2002), 44.

23 Brown, "Illustration and Critique," 10.

24 Betty Carter, The Changing Family Life Cycle: A Framework for Family Therapy (Boston, MA: Allyn and Bacon, 1997), 31.

25 Deborah Anna Luepnitz, Feminist Theory in Clinical Practice (New York: Basic Books, 2008), 56

support, draw attention to, and sustain both undesirable and acceptable behavior. Family system theory aims to identify and reenact behavioral relationships within families. The emphasis is on identifying and halting recurrent patterns of behavioral interactions which involve problematic conduct. When these problem-perpetuating patterns end, the disturbing behavior stops occurring, and the treatment is complete.

According to the family systems theory, the family is the primary interpersonal setting in which personal character traits and the consequent patterns of behavior are learned and reinforced. The therapies based on family systems theory see a person's symptoms developing in the context of family contact. The idea that there is a connection between the diagnosed patient's symptoms and the overall family interaction is axiomatic in family systems theoretical frameworks. Recurring interaction that links one person's problematic behavior with the behavior of other family members become highly valued in family systems theory and therapy.

Dr. Carl Gustav Jung was a Swiss psychiatrist and psychoanalyst who founded analytical psychology. Jung's work has influenced psychiatry, anthropology, archaeology, literature, philosophy, psychology, and religious studies. According to him, the more intensively a family has stamped its character upon the child, the more the child will tend to feel and see its earlier miniature world again in the bigger world of adult life.[26]

Some churches view mental illness as a hereditary curse. A habit or behavior handed down from one generation to the next is known as a generational curse. Parents make an effort to ensure that the life they lead will benefit their children somehow.

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[26] Ronald W. Richardson, "Introduction," in *Family Ties That Bind: A Self-Help Guide to Change through Family of Origin Therapy* (Bellingham, WA: Self-Counsel Press, 2011).

Children put into practice both what they have independently learned and what they have gleaned from earlier generations. Hereditary curses are highlighted in the scripture of the Old and New Testaments. Numbers 14:18 states, "The Lord is slow to anger and abounding in steadfast love, forgiving iniquity and transgression, but he will by no means clear the guilty, visiting the iniquity of the fathers on the children, to the third and the fourth generation."

The lessons a child learns might serve as a guide as they get older. Looking back frequently gives a clear picture of their family's trajectory in life. People carry generational curses from their parents' behavior and experiences. Daily tensions can lead people to say or do what they don't mean. Children notice. The things they carry into adulthood are an excellent illustration of a generational curse.

Many things in families are kept secret until children are old enough to understand. When they learn the truth, a choice must then be made: to follow their ancestors' footsteps and pass on the same bad habits to future generations, or to break the curse and find a means to instill positive family values.

Bowen's observation on the behavior of those cut off from their families of origin can be viewed as an illustration of a "generational curse." He notes:

> People who are cut off from their own parental families are the most vigorous in the attempt to create "substitute" families from social relationships… if social relationships become significant, then tend to become duplicates of their relationships to their parental families. When stress and anxiety increase, they cut off from their social relationships and seek other better social relationships.[27]

Family Systems Theory emphasizes the importance of listening to what family members say and, more significantly, observing the relationship to determine how they

[27] Bowen, *Family Therapy,* 538-39.

say it and the response of other family members. Tracking how one's behavior affects and, typically without conscious awareness, limits the actions and speech of other family members is particularly important in family systems theory. To fully understand family systems theory, observing the patterns in which problem behavior manifests itself is necessary.

The study of family interaction as the setting in which severe behavioral and emotional symptoms emerge was simultaneously discovered by several multidisciplinary research teams working independently across the United States, primarily with hospitalized, emotionally disturbed individuals. This discovery seemed accidental or at least incidental. Dr. Roberta M. Gilbert, a psychiatrist trained in Bowen Family Systems Theory, taught clergy leaders for many years. In *The Cornerstone Concept, In Leadership, In life*, she writes:

> Bowen's concept of the scale of differentiation of self has multiple facet; over the years, my understanding of it has continued to evolve. It offers descriptors of more and less mature functioning. Bowen describes high-level maturity as demonstrated in one who has the courage to define self, who is as invested in the welfare of the family as in self, who is neither angry or dogmatic, whose energy goes to changing self rather than telling others what they should do, who can know and respect the multiple opinions of others, who can modify self in response to the group, and who is not influenced by the multiple opinions of others.[28]

A generational curse can come through our parents' actions and our own experiences. Additionally, stories transmit them. Every child is told stories and given justifications for the actions of adults around them. Some people remember the care they received. These lessons are then applied to adult lives. Though some of those traditions

[28] Roberta M. Gilbert, "Differentiation of Self," in *The Cornerstone Concept: In Leadership, in Life* (Falls Church, VA: Leading Systems Press, 2008), 172.

and tales are doubtless questionable, what do people do if they don't have the opportunity to learn any better?

Deuteronomy 28:15-68 states:

> But if you will not obey the voice of the Lord your God or be careful to do all his commandments and his statutes that I command you today, then all these curses shall come upon you and overtake you. Cursed shall you be in the city and cursed shall you be in the field. Cursed shall be your basket and your kneading bowl. Cursed shall be the fruit of your womb and ground, the increase of your herds and the young of your flock. Cursed shall you be when you came in and cursed shall you be when you go out.

I remember hearing the elders' tales as a child about the challenging situations they faced and how they overcame them. These events ranged from big ones, such as learning how to get to school during a hurricane for a final exam, to minor ones, such as needing an urgent stitch job the morning of a first-ever job interview. The powerful lessons in these stories taught me a lot about finding a way when there didn't seem to be one. These stories shape our behavior and keep us connected to our past. Our acts can establish roots much deeper than the initial narrative, especially if they are recurrent actions.

Despite understanding that the plots of those stories could go wrong, people automatically follow them since they hold such stories dear to their hearts. This habit severely hinders the person's ability to develop and learn independently. Although it is sensible to desire to preserve the past, society is changing quickly. Even though the stories' fundamental themes will hold, each person's situation is unique.

The things we hear, see, and experience have the potential to pass along generational curses. Either you break the curse and find a way to establish good family

values, or you follow in your ancestors' footsteps and pass on their destructive behaviors to the next generation.

There is nothing wrong with trying to be like somebody you admire. However, one must consider how far their route leads them and how far yours will go. Imitation is the highest flattery; staying put and unable to go forward is not.

In an era when family therapy is rediscovering its psychoanalytic roots, it is crucial to comprehend the distinctions between Bowenian and psychodynamic approaches. Though both models explain many parts of human experience, Bowen's concentration is on something other than the intrapsychic experience of the individual. Bowen focuses on the structure and functioning of the system to enable the person to create a new systemic role. In psychoanalysis, by contrast, the relationship between the therapist and the patient leads to self-understanding. Bowenian therapy happens through the planned behavior of the "self in the system" between sessions.[29]

This study bears the risk of oversimplifying Bowen's concept by offering an overview rather than a thorough explanation of the family process. Several issues must be kept in mind when applying a family-of-origin approach. Due to Bowen's emphasis on the long-term to solve the present problems, families could meander down therapeutic paths beyond their need for the quickest route to symptom relief. When there have not been any recent sociopolitical changes, Bowen's method decontextualizes relationship patterns heavily influenced by factors like gender, ethnicity, and class.

The church should be at the forefront of caring for mental illness for various reasons, not the least of which is that mental illness is linked to family systems. For one,

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[29] Brown, *Theory in Ministry,* 282.

there is a biblical justification; the Bible claims that Jesus treated the mentally ill. Scripture contains several instances of Jesus helping people overcome depression, anxiety, worry, fear, and other negative feelings.

Matt. 4:24 states, "And his fame went throughout all Syria: and they brought unto him all sick people that were taken with divers diseases and torments, and those which were possessed with devils, and those which were lunatic, and those that had the palsy; and he healed them."

Jesus himself provided for those who were mentally ill. According to the Bible, Jesus visited every village, preaching, teaching, and performing miracles. Health and healing accounted for one-third of Jesus' earthly ministry. Jesus is more than just our Savior. Another reason we should be concerned about mental illness in the church is because Jesus is our teacher and healer.

The church has long been involved in health care; this is a historical fact. Although some people believe it to be novel, it is not. For over 2000 years, the church has provided medical care for the ill, predating all governments. In actuality, the hospital was created by the church.[30]

About 60 million people in America are dealing with mental illness. So, everyone is aware of someone who is dealing with mental illness. Everyone is aware of a family dealing with mental illness. Since Jesus cares, because it has always been the church's responsibility, and because, practically speaking, we are the first line of defense in caring

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[30] Warren, Ricks, Elke Smeets, and Kristin Neff. "Self-criticism and self-compassion: Risk and resilience: Being compassionate to oneself is associated with emotional resilience and psychological well-being." *Current Psychiatry*15, no. 12 (2016): 18-28.

for people in their misery, the church must care. Before going anyplace else, people first go to church.

Helping a loved one with a mental condition is a shared interest and concern among the church. Making sure that families in the church community and beyond receive the help they need to improve their lives and the lives of their families is something the church needs to comprehend is what the church must do.

When I write about the church and youth of the church and community and beyond, I refer to children and teenagers who start slipping behind in school and quit hanging out with their friends, like my daughter and others. They have started staying in their room for long periods and refusing to leave. Some families have a gut feeling that something is wrong. They are concerned that there might be a mental illness and wonder what its warning signs and symptoms are.

Mental illness symptoms manifest themselves in one of three ways. In addition to behavioral issues, there are issues with mood and thought. A person's mood could change, and they might start sobbing, upset, or even angry. They may struggle to follow one concept with another as their thinking shifts. Their ideas could be more organized and lewder. They might start to exhibit signs of suspicion and even paranoia. Clarification of their concepts and behavior issues are both possible.

Their behavior shifts significantly, which could also mean their food and sleeping habits vary significantly. They can behave strangely and spend the entire night up. Isolation, being wary, or perhaps being so paranoid that they start talking to themselves. They do not just last for a few days; they continue for weeks and months. Another sign of mental illness that families should be aware of is when they start to worry for a family

member's safety or the safety of others. This sign must be brought to the forefront as it is a hallmark of the condition. Many families could have trouble believing what they see, even when it appears obvious. It is possible that they have never gone through this or that the consequences are too much for them to handle.

Some of the few approach people living with mental illness might use to find answers to help their family member is. Please stay out of fights and become familiar with the laws and procedures of the mental health system. Do not go alone or go by yourself. There are individuals and locations to turn to. More than one in five people in this nation have a mental illness. The number of adults and teenagers increases yearly.

The National Alliance on Mental Illness is a volunteer organization that has been around for years. Nationwide, thousands of family members who have received training have experienced this firsthand. They can do this over the phone and in person since they have received training in information and referral. The family-to-family evening educational meetings, offered by many NAMI chapters, are excellent free resources. There are people and places to turn to, so there is no need to journey alone. The church must ask questions and listen because that is how we learn. The church is in a unique position to help people with mental illness. The church must have an understanding of the family system and generational curses. If the church membership understands its strength; it can journey with people living with mental illness.

If the church membership understands the laws of the mental health system; how it functions, they will be better equipped to walk alongside these children and youth with mental illness. Regrettably, the mental health system in this nation is gravely imperfect; perhaps broken. Knowing that the mental health system is broken is something that

families living with mental illness will quickly learn. The church must be able to speak out for these families and their loved ones.

The church must also understand that dealing with mental illness is a marathon rather than a sprint. There are hardly any ailments that develop and disappear in a matter of weeks.

These four principles must be understood by the church for it to be able to explain them to families of people with mental illnesses. Do not go alone; avoid conflicts and discover how the mental health system functions whether you are enrolled. Study the guidelines. Remember that finding mental illness treatment is more like a marathon than a sprint. Recovery is possible with the church being an active partner.

The project I am proposing is related to Family Systems Theory because it emphasizes the significance of family interactions in comprehending human behavior and emotions. In the context of avoidant behaviors by family members, family relationships and feelings like anxiety become examples. The family systems theory examines how individuals interact with one another to ascertain the nature of their relationships. Family systems theory uses observable, interactional processes, such as triangles, coalitions, patterns, redundancy, multiple levels of meaning, and observer-imposed punctuation, to characterize these connection processes.

Family Systems Theory and generational curses for mental illness highlight the spiritual significance of the Biblical components of mental illness and its implications for generational curses. People who suffer from mental illnesses frequently don’t receive social support and are seen as having little social impact. A rising body of literature

criticizes the current approach to mental illness as being essentially oppressive and degrading.[31]

Mental illness results in radical social transformation. It impacts every element of society and has had a long-lasting impact on many people's lives. It offers a fresh viewpoint that can inspire hope and commitment to advancing the radical cause of mental illness rights. Separating people with mental illnesses from others is impossible; they require assistance, not isolation.

Family Systems Theory and generational curses relate to concerns of mental health and mental illness, but it's not apparent what qualifies as a mental disease in the local church. It is crucial to comprehend family systems theory, generational curses, and mental illness in affluent areas to investigate the connection between Family Systems Theory and generational curse.

[31] Marilyn Hickey, *Breaking Generational Curses* (Tulsa, OK: Harrison House), 20.

CHAPTER SIX

PROJECT ANALYSIS

Mental wellness is vital to the values of the United Methodist Church of Bound Brook. Its teachings are rooted in John Wesley's emphasis on personal transformation, holiness, and social justice, recognizing the intrinsic connection between mental wellness and spiritual and communal life.

Based on Wesleyan theology, the church's doctrine views salvation as an all-encompassing and transformative process involving a person's entire being, including their mind, body, and spirit. Therefore, mental wellness is fundamental to this framework, highlighting the correlation between a sound mind and spiritual growth and maturity. The United Methodist Church of Bound Brook fosters a community that actively supports mental wellness, emphasizing compassion and care. They exemplify Christian values, such as love and empathy, and extend these virtues to those struggling with mental health challenges.

Inclusivity is another crucial aspect of the church's theology, where the congregation welcomes everyone. Embracing mental wellness is of utmost importance as it creates an inclusive environment that encourages individuals facing mental health issues to seek help and support within the faith community, free from stigma or exclusion.

John Wesley, the founder of Wesleyan theology, was known for his emphasis on social justice and advocacy for marginalized communities. This foundational aspect of Wesleyan theology highlights the intersection of mental health issues with broader social justice concerns like poverty and healthcare access. An academic exploration of these issues reveals that the United Methodist Church has the potential to effectively engage in advocacy efforts aimed at addressing systemic disparities by promoting mental wellness.

The Christian tradition recognizes the healing ministry as a vital dimension of the Christian mission, and mental wellness aligns with this mission by addressing emotional and psychological wounds. This academic exploration underscores the significance of the church's involvement in mental wellness advocacy.

Wesleyan theology empowers believers through divine grace, making it a vital element of the theological foundation of the United Methodist Church. Promoting mental wellness within the church community allows individuals to seek assistance, embrace self-care, and embark on a transformative journey toward spiritual growth and personal development. This academic exploration underscores the alignment of mental wellness promotion with John Wesley's concept of "Christian perfection."

A blog post on March 11, 2019, on the Robert Wood Johnson Foundation page entitled *Where Mental Health and Social Justice Meet,* by Dwayne Proctor, provides valuable insights into the intersection of mental health issues and broader social justice concerns, highlighting the advocacy potential of the church in addressing these systemic issues.

The importance of mental wellness within a church community is explored in-depth in academic literature, highlighting the significance of authenticity and

vulnerability in creating a healthy community. A transparent and empathetic environment where members can share their struggles and seek help without fear of judgment or stigma nourishes the spiritual fabric of the congregation and fosters a sense of genuine community. This emphasis on mental wellness equips members with emotional resilience, crucial when facing life's challenges while maintaining an unwavering faith in God.

By placing mental wellness at the forefront, the local church can serve as an example for its members and the broader community, embodying principles of well-being and faith that can inspire hope and healing. The United Methodist Church tradition values mental wellness, aligning with Wesleyan holiness, compassion, inclusivity, and social justice principles. By nurturing mental health and creating a supportive environment, a local church can embark on a mission to transform lives and communities through the love and grace of Christ. *Emotionally Healthy Spirituality* by Peter Scazzero offers substantial insights into the interplay between emotional and spiritual well-being within a faith community context, substantiating this exploration.

The methodology for this project employs qualitative research based on action research using qualitative tools. Pre- and post-tests gauged the participants' knowledge and experience regarding mental health. A pre-test assessed the participants' initial understanding of mental health. The subsequent post-test allowed for the measurement of any knowledge gained or changes in perception following the implementation of the clinical model project. Interviews and participant feedback provided valuable insights into the depth of learning acquired through the project.

Focus group discussions allowed for the consideration of individual and group perspectives. This model project's focus group was formed explicitly within the project's context, ensuring that the data collected resonated with the project's goals. One of the primary objectives of this project was to explore why religious and spiritual individuals often hesitate to embrace and understand mental health. The qualitative research approach, particularly the focus group discussions, created a comfortable and non-judgmental setting for participants to share their thoughts and experiences.

The project's hypothesis stated that if the leadership participates in ministry formation training about mental wellness, they will have the knowledge to assist the pastor in creating a mental wellness ministry. This hypothesis addresses the need to combat stigmas and stereotypes associated with mental health within congregations and recognizes the responsibility of leadership to provide pastoral care encompassing mental health.

Quantitative data came from pre- and post-test surveys administered to workshop participants. The workshop included a comprehensive curriculum covering biblical, historical, and theological foundations and basic pastoral care training related to mental and spiritual health.

The focus group consisted of church members representing the project's context, with varying experience in church leadership. Their ages ranged from thirty to seventy, providing diverse perspectives. This project employs various qualitative research methods, including pre-and post-tests, focus journaling, focus group discussions, and reflection papers, to comprehensively evaluate the impact of mental wellness initiatives within the United Methodist Church of Bound Brook. These methods allow for a

thorough understanding of participants' knowledge, experiences, and perspectives regarding mental health and wellness, contributing to developing effective strategies and interventions within the church community.

Throughout our six-week study project, we focused on the theme of "Curative Community: Creating Healing Spaces, Processes, and Support for Individuals with Mental Illness" with our research group. Our study delved into critical areas crucial for understanding mental illness, such as common mental health conditions, suicide awareness, diagnosis processes, available mental health treatment options, the intricate relationship between mental and physical well-being, and strategies for recovery, overall wellness, and building resilience.

Our primary objective was to educate participants on how congregations could create a welcoming environment and foster inclusivity for individuals facing mental health challenges. Additionally, we covered essential aspects such as recognizing when to refer someone to a mental health professional, understanding the referral process for mental health treatment, addressing resistance to accepting mental health care, distinguishing between religious or spiritual concerns and mental illness, and effectively approaching individuals in urgent mental health crises.

Our comprehensive sessions aimed to empower congregational leadership with heightened mental health awareness. By integrating mental health considerations into their spiritual development within the church, leaders could work towards creating a more supportive and understanding community for individuals dealing with mental health issues.

Implementation

The centerpiece of the Doctor of Ministry Project was a six-module workshop. Upon recruiting participant church teams, expectations and the workshop schedule were communicated via email. It was emphasized to all participants that while the information imparted aimed to be beneficial and immediately applicable to our contexts, they were concurrently engaging in a research endeavor.

The workshop curriculum was disseminated through a variety of instructional methods, including lecture-style presentations, group discussions, video presentations, interviews, and case studies. The teaching workshop comprised six modules.

1. Introduction to the of "Curative Community: Creating Healing Spaces, Processes, and Support for Individuals with Mental Illness" theme.
2. Biblical Foundations
3. Historical Foundations
4. Theological Foundations
5. Interdisciplinary Foundations
6. Next Steps

The pre- and post-tests were implemented to gain core knowledge of mental health services and to examine participants' thoughts, attitudes, and feelings regarding mental health within their churches and communities.

Schedule and Overview of Content

The Doctor of Ministry Project comprised six-week sessions, commencing on July 23rd, 2023, and concluding on August 27th, 2023. Invitations to participate in the project were extended to the church council of Bound Brook United Methodist Church, comprising 12 members, of whom 5 elected to partake in the Doctor of Ministry Project. All sessions were conducted in person at Bound Brook United Methodist Church. The sessions were structured based on insights gleaned from my research and sermon series.

The first and last in-person sessions were allocated two hours each to accommodate pre- and post-project questionnaires. Each additional session was slated for a duration of an hour and a half. Despite the session durations ranging between an hour and a half to two hours, incorporating the impartation of new content, fostering a sense of community, and allowing ample time for participant engagement proved challenging, necessitating consideration for time constraints and the cognitive processing demands of the content.

Several participants' responses to the pre- and post-project questions are noteworthy. To maintain anonymity, each participant was attributed a fictional name from the Star Trek TV series. During the first questions, Sisko asserted a confidence in their ability to navigate the world, whereas Participant Odo posited that coping constitutes a nuanced state of mind, dichotomously characterized as either positive or negative. In response to the second question, Sisko contended that individuals might struggle to cope with life situations, whereas Odo delineated instances wherein compromised mental health impairs daily functioning, hindering task completion, emotional well-being, and affective expression.

Transitioning to the third question, Sisko asserted the universality of mental health, irrespective of its qualitative manifestation, contrasting it with the discrete nature of mental illness as a pathological condition. Conversely, Odo underscored the inherent possession of mental health by individuals, contending that mental illness arises solely when mental well-being is compromised, impeding daily functioning. Regarding the fourth question, Sisko shared that mental illness is indiscriminately pervasive, whereas

Picard wrote down the notion that mental illness discriminates based on personal typology, asserting its potential impact across all demographic spectra.

In addressing the fifth question, Torres revealed various modalities for treating mental illness, including inpatient care, outpatient care, group therapy, pharmacotherapy, and individual counseling sessions. In her writing Janeway promoted for pharmacotherapy, therapeutic dialogue with mental health practitioners, and participation in group therapy sessions as efficacious management strategies. In the sixth question, Torres expressed uncertainty regarding the scriptural perspective on mental health and illness, while Sisko articulated a desire for clarification, evidencing a curiosity-driven pursuit of understanding.

Moving onto the seventh question, Janeway professed unfamiliarity with alternative avenues for seeking assistance beyond pastoral consultation, underscoring a deferential reliance upon ecclesiastical guidance. Conversely, Torres contended that ecclesiastical institutions necessitate expansion and enhancement in their capacity to address mental health concerns effectively.

Conclusively, all participants advocated for heightened awareness of the indicators of mental illness to enhance the ministry's responsiveness. They underscored the imperative of integrating discussions on mental illness into sermonic discourse, supplemented by scriptural exegesis elucidating theological perspectives on mental health. These collective endeavors, they argued, are essential for fostering a more enlightened and compassionate approach toward mental health within religious communities.

Throughout the implementation of the "Curative Community: Creating Healing Spaces, Processes, and Support for Individuals with Mental Illness" Doctor of Ministry Project, context associates played a significant role in shaping its design and execution. The project utilized them in this way:

First, context associates provided valuable input in developing the curriculum for the six-week study project. Their feedback and insights ensured that the content was relevant, engaging, and addressed specific concerns around mental wellness. Furthermore, context associates with personal experiences with mental health were encouraged to share their stories. These narratives added authenticity and relatability to the project, fostering empathy and understanding among participants. Church leaders who were context associates contributed insights into pastoral care practices within the congregation. Their knowledge helped identify areas where mental health considerations could be integrated into pastoral care.

Context associates also became advocates for mental health awareness within the church community. They shared information about the project, encouraged participation, and helped destigmatize conversations around mental health. Throughout the project, they provided continuous feedback on the effectiveness of the interventions and the overall impact on the congregation, allowing for adjustments and improvements to be made in real-time.

Moreover, context associates played a crucial role in identifying external resources, such as mental health professionals or organizations, which could provide additional support to congregational members in need. Beyond the formal project, context associates remained engaged in sustaining the initiative. They continued to

champion mental health awareness and support within the church, ensuring that the project's impact endured.

Overall, context associates were integral to every Doctor of Ministry Project phase, from conception to ongoing impact. Their diverse perspectives, personal experiences, and active involvement ensured that the project was relevant and deeply connected to the needs and aspirations of the church community. By harnessing their collective wisdom and commitment, the project effectively transformed the congregation into a more compassionate and understanding "Curative Community" for individuals facing mental health challenges. With the six-week study project, I conducted a three-week sermon series on mental health titled "The Elephant in the Room." The study participants provided feedback on each week's sermon. The participants found the sermon series to be a profoundly positive influence on the congregation's well-being.

In today's fast-paced and often stressful world, addressing mental health from a spiritual perspective is relevant and essential. The series brought about a positive change among the congregation in their awareness of mental health issues in the community. Here is the series:

Week 1: Ruth 1:19-22 "Do not call me Naomi, call me Mara."

In the first week of the series, I focus on breaking the stigma surrounding mental health issues. Many individuals still feel ashamed or hesitant to seek help for their mental well-being due to societal stereotypes. Addressing this stigma within a faith community can be transformative. The sermon emphasizes that seeking mental health support is not a sign of weakness but a courageous step toward healing. By encouraging open

conversations, the church can foster a more accepting environment where individuals feel safe sharing their struggles.

One of the participants wrote in their reflection on the week one sermon, “People are suffering every day. People committing suicide and hurting themselves every day, people we know. We need to show those that we are here and showing up.” Another participant said, “I do not know how I can help those with struggles with mental illness other than being a good lister or suggesting they go for professional help.”

Week 2: Acts 16:13-15, 40 and Matthew 14:22-33 “We are called to be and build the church.”

In the second week, I explored finding strength in vulnerability. Vulnerability is often viewed as a weakness, yet it takes immense courage to be open about one’s mental health challenges. The sermon drew from scripture and personal stories to illustrate how embracing vulnerability can lead to healing and deeper connections within the church community.

It can also provide practical guidance on supporting one another through times of emotional distress. The sermon highlighted that church should be a place to welcome all—rich, poor, and those in between. The church can be a healing place for the workers, travelers, preachers, doubters, the well, and the sick.

In this sermon, one of the participants shared in their writing. “Hopefully, I would be less fearful that my help would be more of a negative than positive. I need to be there to listen and let them talk. I do not have to have all the answers. Just be there for them. We can do more than we think.”

Week 3: Ester 3:13 and Matthew 15:21-28 "In such a time as this, we are positing to be agents of God."

In the final week, I delved into the relationship between faith, resilience, and healing. It can highlight how faith can be a source of strength during difficult times and how resilience is a trait people can nurture. The sermon offered biblical examples of individuals who faced adversity and emerged more robust in their faith. It also provided resources for developing resilience and maintaining mental well-being. I furthermore shared with the church that we are doers of justice and lovers of kindness.

One of the participants shared, "After listening to the scripture and sermon, I hope to be more aware of the mental health of those around me. I found out that 20% of adults are dealing with mental illness." This information was very revealing to her. Another participant shared with me, after the worship service, a song entitled "Cast Out, O Christ." The first verse says, "Cast out, O Christ, cast far away the demons that destroy: the haunting dreads that choke our souls, the hates that stifle joy."

This sermon series encouraged congregants to share their experiences, seek help when needed, and support others to create a church community embodying love, compassion, and understanding. Additionally, offering resources such as counseling referrals or mental health support groups could further enhance the positive impact of the series.

By addressing mental health openly and compassionately, this three-week sermon series helped reduce stigma, promoted mental well-being, and strengthened the bonds of the congregation within the Bound Brook United Methodist Church in New Jersey. It was

a beacon of hope and healing for individuals facing mental health challenges, reminding them that they are not alone on their journey to emotional and spiritual well-being.

The pre-and post-tests tests were implemented to gain the core knowledge of mental health services and examine participants' thoughts, attitudes, and feelings around mental health in their churches and communities.

Pre-Test Questions

Question One – How do you define "mental health?"

Results - the health of your mind and how to handle life's challenges and situations; services that assist in managing your mental thoughts; feeling grounded in peace; health of the mind; unbalance in one's thinking.

Question Two - What is your definition of mental illness?

Results – Mental illness is a disorder that affects mood, thinking, and behavior; it assists your psychological and emotional well-being with a trained person and the ability to move through emotional and psychological experiences positively.

Question Three – What is the difference between "mental health" and "mental illness?"

Some of the Responses – "Mental health" is something we all have. It is our way of coping. "Mental illness" is when your mental health becomes detrimental to daily living.

Results - mood changes, personality, habits, withdrawals; depression, anxiety, schizophrenia, addictive behaviors; depression, OCD, anxiety; depression, bipolar, depression and anxiety; bi-polar, anorexia, multi-personality, paranoid, schizophrenia.

Question Four – What type of person is most likely to suffer from mental illness?

Some of the Responses: I do not believe mental illness is based on a person's type. All types can suffer from mental illness.

Question Five - What are current treatment options for individuals who have mental illness?

Some Responses: Treatment options are patient, outpatient, group therapy, medications, and private therapy sessions with doctors or licensed counselors.

Question Six - What does the Bible say about mental health and mental illness?

Results- 100% said that they do not know.

Question Seven - What steps has the local church taken to minister to persons with mental illness?

Results- 100% said this is an area where the local church needs to expand and improve.

Question Eight - What things must the local church do to improve its ministry to those with mental illness?

Some of the Response: I believe that making everyone more aware of the signs of mental illness will improve the ministry's handling of it. We need to recognize when someone needs help and know where to direct them to get that help.

Post-project questions

Question One – How do you define "mental illness?"

Results – Mental illness is the condition of one's psychological and emotional well-being, encompassing the state of the mind, which can vary from reasonable to poor mental health. It refers to the overall health and functioning of an individual's mind and emotional state.

Question Two - What is your definition of mental health?

Results – Mental health encompasses the overall well-being of an individual's mind, which includes emotional, psychological, and cognitive aspects. It relates to the capacity to manage and navigate various emotional and psychological experiences constructively. Conversely, mental illness refers to conditions that disrupt mood, thinking, and behavior, often requiring professional assistance and treatment. Therefore, mental health represents the equilibrium of one's mental and emotional state, while mental illness characterizes the presence of specific disorders or conditions that impede this equilibrium.

Question Three – What is the difference between "mental health" and "mental illness?"

Some of the Response – Mental health and mental illness are two related yet distinct concepts that are often confused—the primary difference lies in their scope and impact. Mental health is a broader term that encompasses the overall well-being of an individual's mind. It refers to psychological and emotional health, including coping with life's challenges, managing stress, maintaining fulfilling relationships, and making sound decisions. Good mental health enables individuals to function effectively, experience a positive quality of life, and pursue their goals.

On the other hand, mental illness is a specific aspect of mental health that refers to conditions or disorders that affect mood, thinking, behavior, or cognitive functioning. These conditions can be disruptive and have a detrimental impact on an individual's daily life and functioning. Mental illnesses may include depression, anxiety, schizophrenia, bipolar disorder, etc. They require attention, diagnosis, and often treatment, which may involve therapy, medication, or other interventions to help manage and alleviate symptoms.

In summary, mental health is a universal aspect of human well-being that encompasses one's overall psychological and emotional state. Mental illness is a subset of mental health conditions that can impair daily life when not managed or treated effectively. Understanding the difference between the two is essential to promote healthy living and seek appropriate care when needed.

Question Four – What type of person is most likely to suffer from mental illness?

Some of the Responses: Mental illness does not discriminate based on a person's type, background, or socioeconomic status. It can affect anyone, regardless of their circumstances. Several factors contribute to the development of mental illness, and they vary from one individual to another. Some key points to consider include:

Mental illness can affect people from all walks of life, irrespective of their socioeconomic status, age, gender, ethnicity, or educational background. Vulnerability to mental illness may result from genetic predisposition, traumatic life experiences, environmental stressors, chemical imbalances in the brain, and more. While life stressors like poverty, trauma, or conflict can increase the risk of mental illness, they are not

definitive indicators. People facing adversity are more vulnerable, but mental illness can also affect individuals living in relatively stable and supportive environments.

It is essential to eliminate the stigma associated with mental health issues to encourage individuals to seek help and support, regardless of their background or circumstances. Timely recognition and intervention can improve outcomes for individuals dealing with mental health concerns.

In summary, mental illness can impact anyone, and various factors influence it. It is crucial to promote understanding, empathy, and early intervention to support those affected and to work towards reducing the stigma surrounding mental health issues.

Question Five - What are current treatment options for individuals who have mental illness?

Some of the Responses: Treatment options for individuals with mental illness encompass a range of strategies tailored to their specific needs. Here are some of the current treatment options:

Psychiatric medications can help manage symptoms associated with mental illnesses. Healthcare professionals prescribe these medications and can include antidepressants, antianxiety drugs, mood stabilizers, and antipsychotic medications.

Psychotherapy involves discussions with a trained therapist or counselor. Different approaches like cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), and interpersonal therapy (IPT) are used to address specific mental health concerns.

For individuals facing severe mental health crises or who may be a danger to themselves or others, inpatient treatment in a hospital or psychiatric facility provides

intensive care, medication management, and therapy. Outpatient programs offer therapy and support for individuals who do not require the level of care provided by inpatient treatment. These can range from regular counseling sessions to more intensive programs. Group therapy sessions bring together individuals facing similar issues to share experiences, coping strategies, and support. Many people find comfort and assistance in self-help and support groups focused on specific mental health conditions or concerns.

Some individuals choose complementary therapies like meditation, yoga, and exercise to support their mental health treatment. Treatment plans are tailored to the individual's diagnosis, needs, and preferences, often involving a combination of these approaches. Collaborating with mental health professionals is essential to develop an effective treatment strategy. Mental health treatment is continuously evolving, and innovative methods and therapies are regularly created to improve outcomes for mental illness patients.

Question Six - What does the Bible say about mental health and mental illness?

Results- The Bible offers comfort and wisdom regarding mental health and mental illness:

1. **Psalm 34:18 (NIV):** "The Lord is close to the brokenhearted and saves those who are crushed in spirit."

2. **Matthew 11:28 (NIV):** "Come to me, all you who are weary and burdened, and I will give you rest."

3. **Psalm 42:11 (NIV):** "Why, my soul, are you downcast? Why so disturbed within me? Put your hope in God, for I will yet praise him, my Savior and my God."

4. **Isaiah 41:10 (NIV):** "So do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand."

5. **Philippians 4:6-7 (NIV):** "Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus."

6. **Psalm 147:3 (NIV):** "He heals the brokenhearted and binds up their wounds.

7. **2 Corinthians 1:3-4 (NIV):** "Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles so that we can comfort those in any trouble with the comfort we ourselves receive from God."

These verses emphasize God's presence, comfort, and healing for those experiencing emotional or mental distress. They remind us that seeking solace and guidance through faith and prayer is a valuable resource for coping with mental health challenges.

Question Seven - What steps has the local church taken to minister to persons with mental illness?

Results- The local church has taken several steps to provide ministry and support to individuals dealing with mental illness:

The church offers confidential pastoral care and counseling services for individuals facing mental health challenges. Trained volunteers and pastors can listen, pray, and provide emotional and spiritual support. The church has the potential to host support groups that create a safe space for people with mental illness and their families to share their experiences and offer mutual encouragement. The church will conduct educational programs and workshops to increase awareness and understanding of mental health issues, including addressing the stigma associated with mental illness.

The church has an active prayer ministry that includes intercessory prayer for individuals affected by mental illness. The church provides referrals to mental health professionals and local resources for more specialized care if necessary. The church promotes an inclusive and non-judgmental environment, emphasizing that everyone is welcome and loved, regardless of their mental health status. The church collaborates with local mental health organizations and professionals to enhance its ability to support those in need. Additionally, the church has ministries like the prayer shawl, backpack food program, and United Methodist Women small groups that can help those with mental illness.

These steps demonstrate the church's commitment to providing holistic care for individuals dealing with mental health challenges and its dedication to breaking the stigma surrounding mental illness within the faith community.

Question Eight - What things must the local church do to improve its ministry to those with mental illness?

Some of the Response: To improve the ministry offered to individuals with mental illness, the local church can consider implementing the following actions: Actively work to eliminate the stigma associated with mental illness within the church community. Promote understanding, compassion, and acceptance. Offer more support groups and educational programs on mental health. These initiatives can provide practical information on recognizing signs of mental illness and understanding how to offer help.

Train church members, leaders, and staff to recognize when a person may need professional help and provide them with the knowledge of available resources for referral. Make information on local mental health resources, hotlines, and crisis intervention services available so individuals can access help when needed.

Integrate discussions on mental health and different types of mental illnesses into sermon series. Address the spiritual and emotional aspects of mental health within a theological context. Expand the ministry by introducing new programs such as book clubs, workshops, or wellness initiatives focusing on mental health.

Consider having a licensed therapist as part of the church staff or collaborating with mental health professionals to offer counseling services. Increase awareness within the church community about recognizing signs of mental illness and understanding when someone needs help.

By implementing these steps, the local church can further enhance its ministry for individuals with mental illness and create a more supportive and informed environment.

Focus Group Discussions

The establishment of the Focus Group Discussions represented a pivotal step in addressing the acute mental health concerns within the local church community. These discussions provided a platform through which participants engaged in candid, introspective exploration of the church's need for heightened mental health awareness and the provision of relevant services.

One of the primary outcomes of these discussions was the realization that congregants in the church community displayed an open and receptive disposition towards integrating mental health services within the church's offerings. Nevertheless, there remained a prevailing sentiment among participants that church leadership required a deeper understanding and an enhanced appreciation of the pivotal importance of these services. It was universally acknowledged that for the seamless integration of a mental health ministry into the church's programs, church leaders needed to assume the role of champions for this cause.

Moreover, the focus group deliberations underscored the critical necessity for church leaders to undergo mental health services and training. This emphasis on enhancing their capacity to relate to and support congregants grappling with mental health challenges has the potential to cultivate a more inclusive and empathetic environment within the church community.

One of the most formidable barriers revealed during these discussions was the pervasive stigma surrounding mental health concerns within the religious community. Participants lamented how deeply rooted these stigmas were, often preventing individuals from seeking help or openly acknowledging their struggles. In particular, there was

unanimous consensus that the perception of weakness or spiritual inadequacy associated with mental health issues frequently functioned as a deterrent to individuals seeking support. This sentiment finds resonance in Patrick Corrigan's work, *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*, which delves into the detrimental impact of stigma on mental health.

The narratives and experiences shared by participants served as poignant reminders of the immediate imperative to destigmatize mental health issues within the religious context. The Focus Group Discussions were instrumental in shedding light on the potential for the church to evolve into a sanctuary where individuals could openly express their mental health concerns without fear of judgment.

In summary, the Focus Group Discussions not only revealed the readiness of the local church community to embrace mental health services but also underscored the indispensable role that church leadership plays in championing this cause. Furthermore, these discussions unveiled the formidable barriers of stigma that continue to impede mental health dialogue within the religious community, underscoring the pressing need for change.

Summary

The data analysis unequivocally highlighted the pressing need for enhanced mental health training and support for church leaders within the local church. This finding emphasized these leaders' critical role in guiding their congregants in spiritual matters and addressing mental health challenges.

One of the primary recommendations from the data was the necessity for church leaders to receive comprehensive mental health training. This training would enable them to recognize better and respond to their congregants' mental health needs. It became evident that church leaders may need proper education and awareness to address these issues effectively.

In addition to training, the data underscored the imperative to address mental health stigmas within the religious community. Stigmas surrounding mental health can be powerful deterrents that prevent individuals from seeking the help they need. Addressing these stigmas requires open and compassionate dialogue within the church. Congregants should feel that their mental health concerns are not signs of spiritual weakness but rather a facet of their overall well-being. This shift in perception can be instrumental in encouraging people to seek help when struggling with mental health issues.

The data further emphasized that church leaders are pivotal in facilitating congregants' access to mental health services. Their dual role as spiritual guides and community mentors places them in a unique position to influence their congregants positively. There was a suggestion that they should engage in a two-fold approach. First, church leaders should offer prayerful support for congregants grappling with mental health challenges. The power of prayer is a source of solace and comfort for many, and by offering prayers, church leaders can extend their spiritual care.

Second, church leaders should take a proactive role in referring their congregants to mental health services. This involves recognizing when an issue goes beyond the scope of spiritual guidance and requires professional intervention. Encouraging and facilitating

access to mental health services is a tangible way for church leaders to assist their congregants.

Moreover, the data pointed to church leaders' need to prioritize their mental health. This may sound counterintuitive, but it is grounded in the understanding that effective leadership necessitates a foundation of personal well-being. Leaders who care for their mental health are better equipped to serve and support their community. When church leaders neglect their mental health, it can affect their congregants' well-being and ability to provide adequate mental health functioning.

The data analysis confirmed that leaders within the local church have a unique position to address mental health issues within their communities. To do so effectively, they must receive proper training, work towards reducing mental health stigmas, offer prayerful support, refer individuals to mental health services when needed, and prioritize their mental health. By embracing this multifaceted approach, church leaders can become robust mental health and well-being advocates within their congregations.

Focus Journaling Learning

Incorporating Focus Journaling as a critical component within a doctor of ministry project on mental health is an invaluable and strategic approach. This innovative and research-driven method significantly enhances the project's effectiveness and impact. At the core of this approach lies the recognition that mental health is a complex and multifaceted field characterized by nuanced individual experiences, diverse treatment modalities, and an ever-evolving knowledge base.

Focus journalism offers a structured and reflective mechanism for the project participants and myself to process, synthesize, and internalize the information and insights generated during the project study. Through journaling, individuals engage in a cognitive and emotional process that deepens their understanding of mental health issues, encourages critical self-reflection, and fosters greater empathy for those they serve. This approach is especially relevant in the doctor of ministry project, where students aim to develop holistic and spiritually informed interventions that bridge the gap between theology and mental health.

Focus Journaling serves as a repository of personal and intellectual growth. It lets students document their evolving perspectives, challenges, and breakthroughs throughout their doctoral journey. These journals become invaluable resources for self-assessment, formative evaluation, and ongoing professional development, which are essential in the mental health ministry. Focus journalism emerges as a pivotal tool in equipping church leadership in the doctor of ministry program on mental health. It reinforces the integration of theological and mental health knowledge while nurturing a reflective and empathetic approach vital in addressing the complex and sensitive issues within the mental health field. It empowers individuals to drive positive change, advocate for mental wellness, and offer holistic care to those in need.

After reviewing the journal entries from our project participants, I came across one entry that stood out. The author reflected on the intricate relationship between mental illness and biblical teachings and admitted to not fully grasping what the Bible communicates about mental health. However, this admission is not a sign of ignorance

but a humble acknowledgment of the profound complexity of mental health and biblical interpretation.

The journal entry highlights that mental health is a universal concern that has traversed human history, and the Bible offers glimpses into the human condition by presenting accounts of individuals who grappled with profound emotional and psychological struggles. As the author engages with these sacred texts, they confront verses and stories that touch on themes of anguish, despair, and inner turmoil. They prompt them to contemplate the relevance of these narratives to the modern understanding of mental health. The entry emphasizes that the church should be a place of healing and a haven where individuals can express themselves authentically. It is essential to cultivate a compassionate and empathetic environment where those dealing with mental health challenges can find comfort and support.

However, the project participants asked a compelling question: How can the faith community better engage with these biblical passages and apply their wisdom to the contemporary discourse on mental wellness? What spiritual resources and guidance can be extended to those in need? How can we initiate discussions and initiatives that help destigmatize mental health issues?

The project participants recognized the issue's complexity and acknowledged the ongoing need for exploration, reflection, and compassionate engagement with those affected by mental health challenges. They emphasize the significance of an ongoing dialogue that extends beyond the boundaries of the faith community, ultimately fostering inclusivity and empathy in the pursuit of holistic well-being and spiritual growth.

Focused Individual Interviews

The successful completion of this project involved a crucial phase of personal interviews that significantly contributed to the depth and breadth of our analysis. The primary purpose of these individual interviews was two-fold.

First, we strategically conducted these interviews to gather qualitative data that could provide insight into the profound impact of the clinical training program on the participants. Our goal was to delve into the transformative experiences and newfound insights gained by the participants due to their participation in the project. By seeking out their perceptions and emotions, I gained a deeper understanding of their journeys toward a more profound understanding of mental health and its implications.

Second, the interviews were an invaluable means of gaining a deeper understanding of how the participants perceive the concept of mental health itself. I explored their perspectives, beliefs, and attitudes to uncover the subtleties and nuances in their comprehension of this critical subject. Through these interviews, I could extract qualitative data that provided a nuanced portrayal of their evolving mental health awareness.

Last, the interviews provided a safe and supportive platform for the participants to share their personal experiences regarding mental health awareness candidly. These narratives added a human dimension to the research, as the participants could express their triumphs, challenges, and revelations in their mental health journeys. Their stories were not just data points but genuine accounts of their encounters with mental health and the impact of their training.

In conclusion, the personal interviews were a pivotal aspect of this project. They offered qualitative insights into the participants' transformation, elucidating their perceptions of mental health and sharing their authentic experiences in mental health awareness. These interviews substantially enriched the research, adding depth and authenticity to the project's findings.

The structured interview was fundamental in gathering in-depth insights into the participants' perspectives on mental health within their religious community. Comprised of three key questions, this interview aimed to elicit comprehensive responses from the participants.

A. The first question, "What do you think about mental health issues in churches?" sought to uncover the participants' initial perceptions and attitudes toward mental health within the congregation's context. It served as a starting point to gauge their awareness and understanding of this critical issue.
B. The second question, "What sorts of stigmas are there about mental health in your church?" delved into the prevailing stigmas and stereotypes that may exist within the congregation's context concerning mental health. This question allowed participants to reflect on the barriers that might hinder open discussions about mental health and the seeking of support.

C. The third question is, “What should the church’s obligations and actions be concerning mental health?” The church must address the problem and offer a system of referrals for mental health assistance. It encouraged them to articulate the actions they believe the congregation’s context should take to support individuals facing mental health challenges.

In summary, through these three insightful questions, the structured interview offered a platform for participants to express their thoughts, reveal stigmas, and outline their expectations regarding mental health within their church. It provided valuable qualitative data, contributing to a more profound understanding of the subject.

What do you think about mental health issues in churches?

Mental health concerns within the church context require careful consideration. It has become increasingly evident that many local churches neglect mental health issues, inadvertently causing numerous individuals to suffer in silence within their congregations. Unfortunately, many religious communities believe that spiritual bonding alone is sufficient to address any challenges their members may face. As a result, they may not offer the additional assistance and support needed for mental health issues. Additionally, some religious doctrines justify avoiding discussions of this critical matter.

In the Bound Brook community, there is still a lack of understanding and misconceptions surrounding mental health. Conversations about mental health often involve judgment, stigmatizing labels, and a lack of empathy and support. It creates an

environment where individuals struggling with mental health issues may feel isolated, judged, or dismissed. It is clear that addressing mental health within the context of religious institutions and broader society is not just a matter of convenience but a pressing necessity.

To effectively address mental health concerns, individuals facing these challenges must receive guidance from certified professionals who can provide counseling services. Unfortunately, many churches and religious communities may lack the resources or expertise to manage the intricate mental health issues that individuals encounter in today's complex world.

In conclusion, religious institutions must recognize the significance of mental health and collaborate with professionals to create a supportive and empathetic environment for their members. The church can contribute meaningfully to its congregation's mental health and well-being through education, understanding, and commitment to providing adequate resources and support.

What sorts of stigmas are there about mental health in your church?

Stigmas associated with mental health issues within religious contexts can pose significant barriers to individuals seeking help and support. These stigmas often emerge from the intersection of deeply held beliefs and a lack of understanding about mental health.

Consequently, addressing these stigmas becomes a critical aspect of creating an inclusive and supportive community where individuals can access mental health services without fear of judgment or discrimination.

The stigmas surrounding mental health in religious communities can harm individuals and their willingness to seek help. Many of these stigmas are rooted in misconceptions and ignorance about mental health issues. When individuals in a religious setting experience mental health challenges, they may encounter resistance or reluctance to access mental health services, particularly if their struggles seem at odds with their community's perceived spiritual or moral values.

As a result, these stigmas often deter individuals from seeking the help they genuinely require. The fear of being unfairly labeled as "crazy" or experiencing isolation from their faith community can be overwhelming. Additionally, there may be concerns about placing trust in mental health professionals, particularly if these individuals lack a deep understanding of religious values and practices. This complex web of stigmas can create a sense of isolation, making it difficult for those needing support and care.

Addressing these stigmas is a matter of personal choice and a collective responsibility. The first step in dismantling these stigmas is to educate religious communities about the realities of mental health. We can break down barriers and challenge misconceptions by fostering a greater understanding of the complex nature of mental health issues. This can help individuals realize that experiencing mental health challenges is not a reflection of their faith or morality but a part of the human experience.

Normalization is another crucial aspect of confronting these stigmas. It is essential to change the discourse around mental health, emphasizing that seeking help is a sign of strength rather than weakness. We can create a more supportive and compassionate community by acknowledging that mental health is as important as physical health.

Ultimately, religious communities are responsible for creating an environment where individuals feel safe and encouraged to seek mental health services when needed. Addressing these stigmas can promote well-being and ensure that no one feels isolated or excluded due to mental health challenges. Removing these stigmas is a testament to our commitment to compassionate care and a reflection of our dedication to building a healthier and more inclusive community for all.

What should the church's obligations and actions be concerning mental health?

The church's role in addressing mental health is of profound importance, carrying a significant responsibility to create a supportive and inclusive environment for its members. To fulfill this responsibility effectively, the church must recognize the significance of mental health and take proactive steps to raise awareness and promote mental well-being.

Primarily, the church must acknowledge that mental health is essential to overall well-being. This recognition should begin at the pulpit, where religious leaders can play a pivotal role in normalizing discussions about mental health. By addressing mental health concerns from the pulpit, the church can send a powerful message that seeking help for mental health issues is acceptable and encouraged.

The church's responsibility goes beyond mere awareness. It should actively educate its members about mental health, dispelling stigmas and misconceptions that often deter individuals from seeking help. While the potential for understanding mental

health within the church exists, church leaders and pastors must take the lead in acknowledging its significance and advocating for its importance.

The church must undergo a paradigm shift in its approach to mental health ministry to address the prevailing stigma surrounding mental health. This transformation is vital in nurturing healthy minds and lives within the community. Rather than viewing mental health as an isolated issue, the church should integrate it into its holistic ministry, recognizing its deep connection with spiritual well-being.

While the church may not directly provide mental health services within its walls, it can be a vital gateway for its members to access the help they need. It can do this through a comprehensive referral system connecting individuals with professional mental health services. By maintaining a network of trusted mental health providers, the church ensures that its members receive appropriate care when necessary.

Furthermore, the church can empower its leadership and members to become well-informed about mental health issues, offering psychoeducational guidance and resources. This approach equips the church community with the knowledge and tools to address mental health concerns proactively. By fostering a culture of understanding and support, the church can play a vital role in promoting mental wellness among its congregation and the broader community.

In summary, the responsibility of the church regarding mental health is multifaceted. It involves raising awareness, promoting education, and reducing stigma. By addressing mental health issues openly and compassionately, the church can fulfill its mission of providing holistic support to its community, addressing the well-being of both

body and mind. This holistic approach can profoundly impact its members' mental health and spiritual well-being.

Summary

The data provides valuable insights into the interconnectedness of mental health, spiritual well-being, and the church's role in addressing these critical aspects of human life. To utterly understand the importance of mental health, the church must recognize that it is an integral component of one's spiritual and emotional development. This holistic perspective on mental health is pivotal for promoting well-being within the church community.

Mental health is not a separate entity but an intrinsic part of an individual's health. The data emphasizes the need for the church to shift its perspective and embrace the idea that mental health and spiritual development go hand in hand. By acknowledging the interplay between mental and spiritual aspects, the church can better understand the profound significance of mental health.

Moreover, the data underscores the church's responsibility to provide primary pastoral care to address mental health issues. It reveals that many individuals within the church community look to their religious leaders and the church for guidance and support in times of mental health challenges. This fundamental role in offering pastoral care extends to creating an effective and efficient system for addressing mental health concerns at a basic level.

The church's involvement in mental health ministry goes beyond traditional spiritual matters; it encompasses the holistic well-being of its members. The data highlights the necessity of equipping the church to address mental health's psychological

and spiritual aspects. By doing so, the church can fulfill its responsibility to provide a supportive and caring environment for individuals facing mental health challenges.

Furthermore, the data suggests that as the church becomes more aware of the psychological and spiritual benefits of addressing mental health, it can play a significant role in dispelling stigmas surrounding this vital issue. The church can catalyze change by promoting understanding, empathy, and acceptance. By actively engaging with the topic of mental health, the church can contribute to the broader conversation and advocate for a more inclusive and compassionate society.

In conclusion, the data underscores the importance of embracing mental health as integral to spiritual and emotional development. It emphasizes the church's responsibility to provide pastoral care and create efficient systems for addressing mental health concerns. The data also highlights the transformative potential of the church in reducing stigmas surrounding mental health by promoting psychological and spiritual well-being. By recognizing the profound interconnectedness of these aspects, the church can better serve its members and contribute to a more empathetic and inclusive community.

Concluding Thoughts on Curative Communities Summary of Learning

The project accomplished the overarching goals set at its inception. These goals were designed to address the pressing issue of mental health awareness within the Bound Brook United Methodist congregations and underscore its significance in spiritual identity and development. The first goal aimed to explore the importance of mental health awareness within the church community. The project effectively demonstrated that mental health awareness is vital and a fundamental aspect of a person's spiritual journey.

The second and third goals highlighted the need to establish the scientific foundation of mental illness, dispelling any misconceptions or stigmas surrounding it. The project provided substantial evidence to support the notion that mental illness is a scientifically proven condition, thus promoting a more informed and compassionate perspective within the congregations.

The fourth goal focused on creating a clinical model to address mental health effectively within the congregations. By implementing workshops and educational sessions, the project unequivocally illustrated the dire necessity of mental health education within the church context.

Goals five and six aimed to nurture empathy, compassion, and a profound understanding of how mental illness impacts individuals. The project succeeded in expanding participants' perspectives, encouraging them to approach mental health with increased sensitivity and awareness.

The project effectively addressed the established goals, emphasizing the critical role of mental health awareness within the Bound Brook United Methodist congregations. It educated participants and fostered empathy and compassion, promoting a more supportive and informed church community. The project's success reaffirms the importance of mental health awareness within religious contexts and its intrinsic connection to spiritual growth and development.

Learning from the Project

The project delved into the intricate relationship between mental health and spirituality. It revealed that mental health is not an isolated aspect of human existence but is intricately woven into the fabric of our spiritual identity and development. This

understanding was developed by comprehensively examining biblical, historical, theoretical, and theological perspectives. From this, it was established that mental health is relevant to our well-being and is integral to our spiritual journey.

One main issue the project addressed was why clergy and congregations often refrain from engaging with mental health services. This challenge was approached with sensitivity, and through discussions and workshops, potential barriers were identified and mitigated. These reasons included stigmas, misinformation, and a lack of awareness regarding the importance of mental health services within congregations and the broader community.

The project's significant outcome was developing a clinical model to address mental health concerns within congregations effectively. This model was fine-tuned to the unique dynamics of religious communities and laid the groundwork for providing essential mental health support to congregants. By equipping leadership with the necessary skills and understanding through tailored ministry formation training, this model can positively influence and extend the reach of mental wellness ministries.

Furthermore, the project uncovered a critical hypothesis that shaped its trajectory. It posited that if church leadership actively participates in a ministry formation training focused on mental wellness, they will acquire the competencies and insights required to collaborate with the pastor to create a mental wellness ministry. This hypothesis, backed by practical evidence and participant experiences, underscores the pivotal role of education and awareness in fostering effective mental health ministries.

Through this project, it demonstrated that congregations that prioritize mental health awareness are better equipped to support members of their community who may

be facing mental health challenges. These congregations can provide care, support, and services to needy individuals by increasing their understanding and empathy around mental health. This initiative has also established partnerships with various spiritual and community organizations, offering affordable mental health services and making churches a valuable resource for referrals and education within a religious context. These partnerships reinforce the church's role as a crucial resource for addressing mental health needs in the broader community. Moreover, the project has sparked essential conversations and raised awareness around mental health in religious communities, fostering a more compassionate and empathetic environment where everyone feels heard and supported.

In summary, this project has explored the complex intersection of mental health and spirituality within congregations, developed a clinical model, and emphasized the correlation between self-awareness and tangible support for others. The project has discovered that congregations that are more self-aware of mental health are better equipped to support those within their community who may be struggling with mental health challenges. By expanding their knowledge and empathy around mental health, congregations can provide care, support, and service to individuals who need it.

Overall, the project has explored the intricate convergence of mental health and spirituality within congregations, developed a clinical model, and highlighted the connection between self-awareness and practical support for others.

Project Reflections

Upon reflection, several critical aspects of the ministry project could have been approached differently, potentially yielding more effective outcomes. While not meant to discredit the project's achievements, these proposed changes offer insights for future endeavors in similar contexts.

First, a comprehensive study of counseling and referral services near the United Methodist Church in Bound Brook and its surrounding community would have significantly enhanced the project. This knowledge would have enabled the project to establish more effective partnerships with local mental health service providers. By fostering more robust connections with such services, the project could have ensured congregants and community members had clear, accessible pathways to professional mental health support. This enhancement would have been a significant step towards reducing the stigma surrounding mental health.

Additionally, diversifying the voices and perspectives included in the project's study would have been valuable. While the project was undoubtedly beneficial, involving a more varied group of individuals would have allowed for a richer understanding of mental health within the context of the church. Diverse viewpoints, experiences, and backgrounds can shed light on unique challenges and needs related to mental health. This broader perspective would have led to more comprehensive and inclusive recommendations for addressing mental health issues within the church.

While the project undoubtedly made significant progress in addressing mental health in the church context, these suggested enhancements provide valuable lessons for future initiatives. Through comprehensive research, diverse perspectives, and

empowering clergy, similar projects can have an even more significant impact in reducing the stigma and improving mental health within the church and the broader community.

This ministry project has given birth to a profound revelation regarding the imperative need for the harmonious integration of mental health and spirituality within the church. It has become evident that separating these two facets of human experience can lead to significant gaps in understanding and support for congregants' overall well-being. Through this realization, the project has unveiled the importance of acknowledging this connection and the immense need for individuals passionate about the confluence of mental health and spirituality.

One of the project's notable outcomes is the revelation of a substantial gap in mental health theology. Mental health theology represents an innovative approach that explores the interconnectedness of the mind, body, and spirit and their profound impact on our spiritual and psychological functioning. It embraces the recognition that spirituality encompasses the entirety of human life, encompassing religious, psychological, mental, and emotional dimensions. This comprehensive perspective underscores the notion that individuals' spiritual well-being is inseparable from their mental and emotional health.

The ultimate goal is to transform the church into a holistic and health-conscious entity that ardently lives out God's mission to share the Gospel and the Good News. By embracing mental health theology, the church can become a beacon of understanding and support for its members, addressing their emotional and psychological needs while nurturing their spiritual growth. In this transformative process, the church moves from an

approach that compartmentalizes aspects of human existence to one that acknowledges and integrates the full spectrum of human experience.

Integrating mental health and spirituality offers a more comprehensive and compassionate response to people's multifaceted challenges. It helps congregants navigate the complexities of their spiritual, mental, and emotional well-being. This project underscores the pressing need for dedicated individuals to delve deeper into the intersection of mental health and spirituality. By fostering a greater understanding of this relationship and expanding the realm of mental health theology, the church can genuinely fulfill its mission of sharing the Gospel and the Good News.

This project has broadened my comprehension of how mental health services can effectively operate within the church and community. Developing fruitful partnerships is crucial for the benefit of both the church and community agencies. While mental health agencies can provide valuable mental health training, they should always prioritize confidentiality and proper consent when offering professional mental health services. Establishing effective boundaries, confidentiality, dual relationships, and adequate client consent is critical to providing appropriate mental health services.

Due to this project, The United Methodist Church of Bound Brook has successfully established relationships with the county Department of Human Services and partnerships with the local library and police department. Through these three agencies, The United Methodist Church of Bound Brook has become a secure haven where individuals with mental health issues can speak to a licensed social worker provided by the Department of Human Services. This initiative is called the Community Police Alliance, and the coordinator receives, analyzes, acts upon, and follows up on referrals

provided by the Bound Brook Police Department and residents to provide access to programs and services that can improve lives. The Community Police Alliance aims to reduce harm to the public, save law enforcement resources, and create a better community for everyone by improving the living situation of residents and families before they reach a crisis point.

According to the United States Census, more than 50 percent of Bound Brook's population is Hispanic, and many residents speak Spanish as their primary language at home. Having mental health professionals who speak Spanish is imperative.

The diagnosis and treatment of mental health is a complex and sensitive topic. Psychoeducational knowledge is invaluable and provided by mental health practitioners to ensure successful therapy. For those seeking information, churches can serve as a valuable resource. By joining a church, individuals can access secure spaces to inquire about mental health and efficient therapies.

Church members are entitled to readily available and reasonably priced mental health services. Churches have the power to connect their congregants with mental health resources effectively and offer essential clinical treatments through proper training in pastoral care. Successful pastoral care programs and services can help members overcome mental health obstacles and offer valuable referral services.

As Christians, we are called to provide healing and compassion to anyone experiencing physical, emotional, or mental suffering. The United Methodist Church is committed to supporting everyone's mental health and providing assistance to those who are suffering from mental illness. The church bears witness in numerous ways, including self-care, prayer, healing, education, and activism.

Financial assistance is crucial for churches to provide quality services, education, and promote mental health awareness. The financial aspect of providing adequate mental health treatments within the church is essential.

Nowadays, churches are increasingly hiring trained and licensed mental health professionals to provide direct treatment and psychoeducational support to their members. However, it's also essential for church leadership, especially pastors, to receive training and education to serve their congregation during this transition effectively.

It's a common misconception among churchgoers that mental health services provided by the church are free. The church must educate its members on the value of mental health services and the necessity of funding to provide professional and effective care.

Building a robust network that recognizes the distinct needs and situations of the church is of utmost importance. This mental network must have a comprehensive understanding of the emotional and spiritual necessities of the local congregation. Possessing sound knowledge in theology and psychology can prove beneficial in aiding the mentally unwell members of the community. A deep comprehension of the connection between spiritual and psychological facets of human life can assist in guiding the congregation toward personal growth.

Conclusion

Recognizing the importance of mental health services is crucial for the church. Community leaders can shape public perceptions about mental illness, and as influential figures, they can set and communicate social standards that the general public follows. Therefore, it is the responsibility of leaders to change the public's opinion of mental

illness through their actions and ideas. Spirituality and mental health are interconnected, as God addresses the psychological, emotional, and spiritual aspects of our existence. Therefore, integrating mental health services and spirituality within the church is highly necessary.

This study emphasizes the benefits of mental health services and awareness for the spiritual growth of any church. Since people comprise a mind, body, and spirit, the mind plays a crucial role in our lives. Therefore, the church must prioritize the mental health of its congregation and clergy by providing mental health services, collaborating with mental health professionals, and educating their members.

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